1985/86
Assessment Project

Aged, Disabled & Chronically Ill

Sponsored jointly
by
Dept. of Health
and
Dept. of Social Services

Gov't of the N.W.T.

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Aged, Disabled, & Chronically Ill Assessment Project Discussion Document

The information and recommendations contained in this report are those resulting from the study team's review and findings. The document should not be construed as representing policy of the Minister of Health or the Government of the Northwest Territories.

The intention in releasing this information is to stimulate discussion and obtain feedback to assist the Department of Health and Department of Social Services in formulating recommendations to the Minister for his furtherance to the Executive Council for consideration.

1985/86 ASSESSMENT PROJECT

AGED, DISABLED & CHRONICALLY ILL

REPORT

Completed by Project Officers

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for

Department of Health

and

Department of Social Services

Government of the Northwest Territories

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Notice: Certain information collected by the project officers is Classified as Medical/Confidential in nature and has therefore been edited from this public discussion document.

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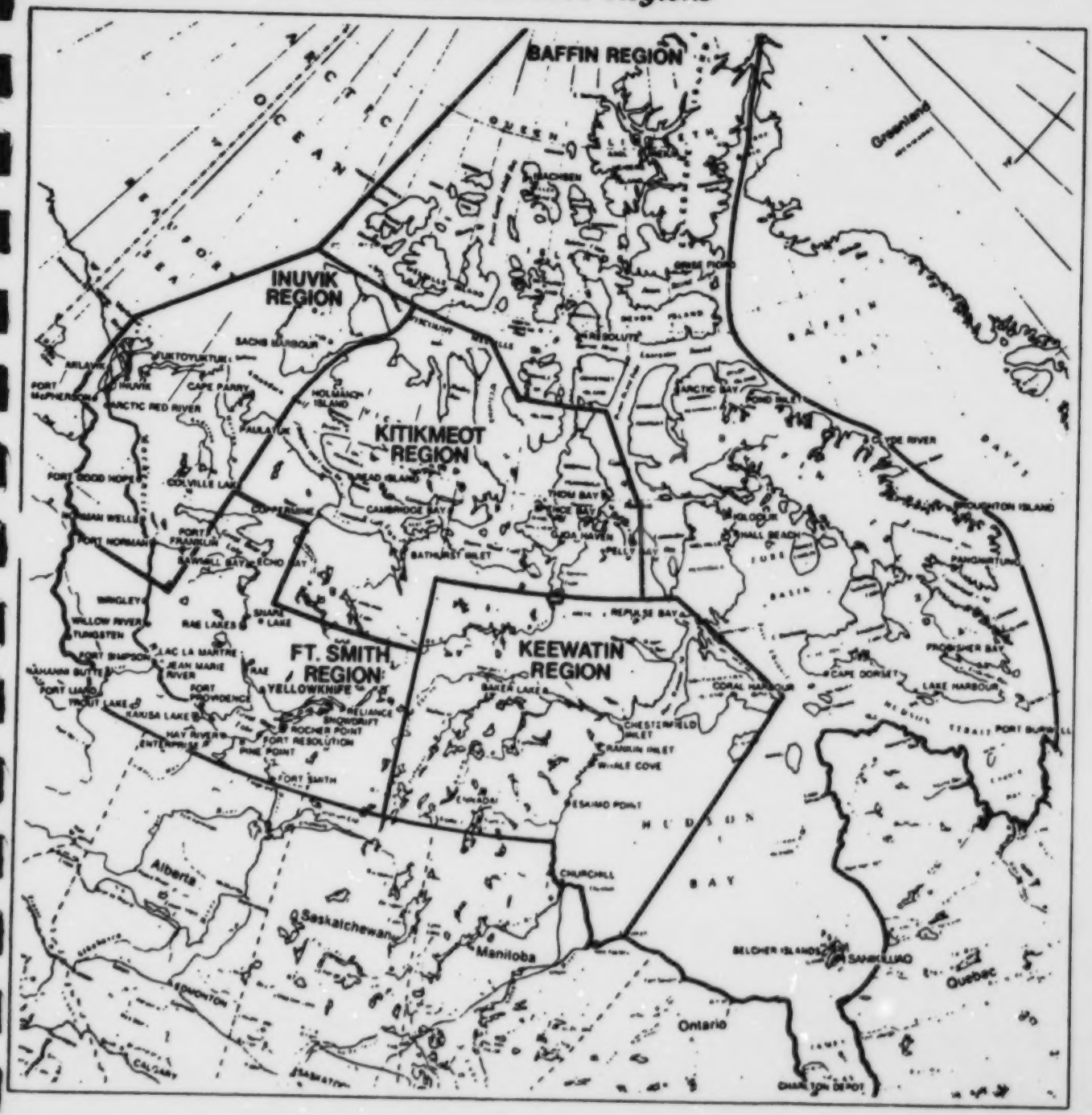
The Northwest Territories Administrative Regions



Section 1

Executive Summary

and

Recommendations

EXECUTIVE SUMMARY

The Territorial government has a responsibility to respond to changing circumstances and to provide positive leadership in addressing major social and economic issues. The development of policies and programs to respond to this increasing elderly population, or indeed to the special needs of other members of society, clearly falls within this mandate. Recognition of this responsibility does not suggest that government either could, or should, "do it all". While government must provide leadership and facilitate necessary changes, the development of appropriate responses has to involve the co-operation and assistance of all elements of our society.

By 2001, it is projected that there will be approximately 3129 N.W.T. residents who are 65 years of age or older. This will represent a 242% increase in this particular age group from 1986. Other age groups are increasing at similar rates and all age groups have needs.

The G.N.W.T. Department of Health received priority funding and, working jointly with Department of Social Services, initiated a comprehensive review of services to Aged, Disabled and Chronically ill citizens in the N.W.T. Two project officers were employed by the Department of Health to undertake the review and to present their recommendations for consideration by the Departments involved. This work commenced in September 1985.

The primary objectives of this project were to:

1. obtain baseline data identifying the needs of Aged, Disabled, and Chronically ill persons in relation to the existing recognized levels of care;

2. identify support services, programs, and facilities already present in the community, those being planned by the community and the potential for the community to provide certain services in the future;

3. collect and update information on Northerners who are in the care of institutions in southern Canada;

4. provide some "in-service" training/assistance for local personnel (e.g. nurses and social workers) in their particular community as to the completion of Assessment and Placement records and the procedures to follow when service is required; and

5. assist in developing a plan to address current and future needs from programs and services to maintain personal independence.

The report describes in detail, the study methodology and findings by region and by individual community. It contains 59 recommendations which will, in the view of the project officers, lead to a more effective and affordable system of health and social service care for clients.

The recommendations address the following areas of concern:

1. The basic philosophy on which to build Programs and Services

2. Home and Community Care Services
   -Support for existing Programs/Services and volunteerism
   -Housing
   -Accessibility for Infirmed/Disabled Persons
   -Homemaker Services
   -Home Nursing Care
   -Co-ordinated Homecare Programs
   -Alcohol & Drug Programs
   -Mental Health Care
   -Rehabilitation Services
   -Early Intervention projects
   -Community Health Representatives (C.H.R.)
   -Alternatives to Institutional Care
   -Elder well-being

3. Long Term Care Facilities
   -Institutional Care
   -Visitation Travel Benefits for Persons in Institutional Care and their Families
   -Repatriation of Clients

4. The Continuum of Care
   -The Continuum of Care Organization and Management
   -Management and Client Information System
   -Revisions to current assessment forms
   -Inter-Agency Relationships and Communication
   -Translation of Information
   -Levels of Care
   -Community visits

The question of how these recommendations might be achieved and implemented will of course, have to be addressed through departmental discussions, and consultation with the regions and communities involved and should include both clients and service providers. Certain points should be noted regarding the proposed strategies.

First, the central theme of the report and it's proposals is to improve and/or maintain health and functional status of the Aged, Disabled, and Chronically ill (primarily through enhanced community care and services) and, thereby to minimize displacement from the client's home community and to reduce preventable and inappropriate institutionalization.

Second, the report is based on the premise that an appropriate response cannot be achieved through a series of ad hoc and fragmented initiatives. Services and programs for clients must be planned, implemented and delivered on a comprehensive holistic basis.

Third, evolution is often based on the identification of existing and emerging issues and the subsequent creation of new strategies and methods. Consequently, the report focuses on areas in which further

improvements or innovations are required. The identification of shortcomings in existing programs should not be construed to suggest that services are unsound or require total transformation. Nothing could be further from the truth. Nevertheless, we must continue to step back and review/evaluate current programs and services and respond creatively to changing circumstances.

Fourth, it should be noted that the recommendations if put into effect, will not provide early relief for either Department of Health or Department of Social Services budgets. In fact, in the short term there will be a requirement for increased funding to provide the required care for people. In the long term however, home and community programs will moderate the need for institutional (more expensive) care and of greatest importance, the welfare of the individual person will be maximized.

Finally, this report is not a technical paper, nor was it meant to be. It is rather a current picture of programs and services and is intended to provide information and recommendations for future action and initiating a complex process involving the organization of efforts at all levels to meet the needs of Aged, Disabled, and Chronically ill persons in the N.W.T.

The report makes 59 recommendations:

Recommendation # 1

PHILOSOPHY FOR PROGRAMS & SERVICES

That: the G.N.W.T. Departments of Health and Social Services adopt the following philosophy for provision of care programs and services being provided to N.W.T. residents.

THE INDIVIDUAL

The care of the aged, disabled & chronically ill must be based on respect for the individual as an independent member of society who has the right to make decisions about his/her life and to function with those choices in as normal a setting as possible. For most, this can best be achieved through care services provided in the home.

Individuals should not be institutionalized until all other avenues of care have been explored and deemed inappropriate.

HOME CARE PROGRAMS

Home care programs need be founded on the following beliefs:

- Individuals can usually retain greater independence and have more control over their lives in their own homes rather than in a long-term care facility or other institution.
- Most individuals prefer to remain at home and to receive any required services at home.
- Existing support provided by families and friends should be preserved and, if necessary, supplemented with respite care.

- Services should be provided to assist individuals to retain (maximum) independence at home, but the provision of services is not intended to create unnecessary dependencies in individuals nor to replace assistance usually provided by the family or community.
- Individuals requiring home care services should participate in identifying their needs, establishing goals for services provided and developing plans to meet the goals.
- Home care programs must respect the right of the individual to accept or refuse any services recommended after assessment.
- The need for home care services can be met most effectively if significant responsibility for planning and delivery of services is exercised at the local level.
- There is a responsibility to promote the participation of volunteers.
- We should be continually seeking new ways and means of responding to identified needs in the communities.

INSTITUTIONAL CARE

Institutional care need be founded on the understanding that:

Even when institutionalized, the individual must continue to retain the right to privacy and to remain independent in every way possible. This requires that the institutional setting be developed from a medical-custodial model toward a social-developmental model. This change should be reflected in continuing care and should emphasize personal dignity and independence, and encourage maintenance of the person at his/her level of care together with rehabilitation, remotivation and enrichment of the whole person.

The philosophy that a personal care home or long-term care facility should be a "home away from home" is admittedly difficult to achieve, but not impossible. There must be flexibility in schedules of facilities that allow residents to make choices about their daily living situations. Each resident's room should lend itself to individuality and to privacy to such an extent that visitors will see a reflection of the individual "at home" in his/her room.

While the individual is receiving long-term care, relatives should be encouraged to maintain supportive family ties. Residents should be provided with a social network in the institution that is conducive to individual well-being. The resident should have access to a private area where he/she is able to continue personal relationships with family and friends. Along with the privilege of placing a family member in continuing care facilities, family and friends have a responsibility of giving support and affection to that individual.

Each person receiving any type of continuing care has the right to a high calibre of service by trained staff. Staff education is a high priority and must include understanding of how to help, comfort and alleviate pain and distress of clients and families as well as to treat their disabilities whether they receive care at home or in an institution.

Even though the later years may in some cases bring physical and social stress, this part of life still remains a time of growth and self-realization. These positive aspects of aging need to be emphasized by programs and policies encouraging the input of those receiving continuing care.

CONTINUUM OF CARE

A continuum of care must be provided for the care of the aged, disabled & chronically ill.

This continuum is a system of linkages from in-home (or alternate home) care services to long-term care facilities and hospitals or other alternate institutions (e.g. psychiatric facilities) to ensure continuity of care without interruption for those moving within the care system. It involves providing the most appropriate care setting whether that means in the person's home, an alternate residence, or an institution.

Recommendation # 2

MAINTAIN EXISTING PROGRAMS & SERVICES

That: existing Health and Social Services programs and services be maintained and expanded where the needs exist.

Recommendation # 3

RECOGNITION OF THE ROLE OF VOLUNTEERS

That: in recognition of their valuable contribution, the Government undertake to support and expand the role of volunteers wherever possible.

Recommendation # 4

HOUSING

That: when planning the yearly housing allocation for a particular community consideration be given to the needs of the Aged, Disabled and Chronically Ill for the development of:

- one (1) bedroom houses;
- one (1) bedroom or batchelor suites in the form of row housing or Senior Citizen's Homes;
- "Granny/Grandpa" suites to existing homes.
- provision for the extended family in seniors own home

Recommendation # 5

HOME REPAIR GRANTS FOR ELDERLY & DISABLED PERSONS

That: existing grants for elderly homeowners be maintained by the N.W.T. Housing Corporation with a view to increasing the present funding allowance.

Recommendation # 6

INFORMATION ON GRANTS

That: information regarding housing improvement grants for seniors and disabled persons be circulated to all community councils and social service staff.

Recommendation # 7

SPECIAL NEEDS FUND

That: the NWT Housing Corporation (in consultation with the Department of Social Services) develop a "Special Needs Fund" for use in providing accessibility type renovations for clients (e.g.. ramps, grab bars, etc.).

Recommendation # 8

ASSISTANCE ON THE BASIS OF NEED

That: the "Special Needs Funds" be based on need whether the home is government owned or private.

Recommendation # 9

ACCESSIBILITY STANDARDS

That: "Accessibility Standards" be developed to ensure that barriers to access by aged and disabled persons are minimized and that these be applied to all new public buildings/public housing units being built or renovated in the future.

Recommendation # 10

MULTIPURPOSE HOMES

That: in small communities the merits of construction of multipurpose homes be considered.

Recommendation # 11

FUTURE CONSTRUCTION PROJECTS

That: in future, where accommodation for senior citizens is being approved for construction, that attention be paid to the fact that personal care may need to be provided there and thus accessibility and layout is a prime concern.

Recommendation # 12

G.N.W.T. BUILDINGS

THAT: The Executive Council of the Government of the Northwest Territories (GNWT) establish policy direction that all public buildings constructed, renovated, leased or funded by the GNWT be required to be architecturally accessible to infirm/disabled clients as a condition for funding.

Recommendation # 13

DESIGN ACCESSIBILITY

THAT: The GNWT encourage community authorities (e.g.. Community Councils, Band councils) to discuss accessibility design concerns with building owners as part of the construction or renovation approval process.

Recommendation # 14

HOMEMAKER/HOME HEALTH AIDE TRAINING

That: a comprehensive Homemaker (Home Health Aide) training program be developed to provide instruction to existing and future workers and provided in each region of the NWT.

Recommendation # 15

POLICIES & PROCEDURES

That: in conjunction with the training program for workers, that policy and procedure guidelines be provided to supervisors (e.g. job descriptions, recording and reporting, evaluation of services).

Recommendation # 16

MANDATE FOR COMMUNITY NURSES

That: discussions be held with appropriate authorities regarding extending the mandate of Medical Services Nurses to include provision of home nursing care of clients.

Recommendation # 17

STAFFING REVIEW TO ENSURE THERE IS MANPOWER TO DO THE JOB

That: an examination of existing community nursing and Social Services staffing be undertaken (for each community).

Recommendation # 18

ROUTINE RELIEF OF NURSES

That: the practice of utilizing nurses in stations for routine relief at other stations be minimized.

Recommendation # 19

REGIONAL FLOAT BACK UP

That: a float pool of registered nurses be developed at Regional Headquarters to provide for routine relief and for assisting stations experiencing peaking workloads.

Recommendation # 20

EXISTING PROGRAMS

THAT: existing programs be maintained, monitored for workload and changes, and adjusted accordingly to ensure that needs of all clients are being met adequately.

Recommendation # 21

DEVELOPMENT OF FUTURE HOME CARE PROGRAMS

THAT: Co-ordinated Home Care programs be established in the following communities:

Baker Lake
Cambridge Bay
Coppermine
Fort Simpson
Iqaluit (Frobisher Bay)
Rankin Inlet

Note: These are alphabetically listed not prioritized.

Recommendation # 22

HOME CARE DELIVERY IN SMALL COMMUNITIES

THAT: discussions be held regarding development and implementation of a model for Home Care program delivery in small communities.

Recommendation # 23

ALCOHOL & DRUG PROGRAMS & SERVICES

That: N.W.T. Alcohol & Drug Services (Social Services) and N.N.A.D.A.P. (National Native Alcohol & Drug Abuse Program - funded by Health & Welfare Canada) continue funding and evaluating existing alcohol and drug programs, and encourage the development of programs in communities where no programs currently exist.

Recommendation # 24

ASSESSMENT OF MENTAL HEALTH SERVICES

That priority be given to the establishment of a comprehensive Mental Health Care Assessment Project to review:

1. appropriateness and effectiveness of existing programs and services;

2. circumstances and conditions which create mental health problems in the north;

3. options which may exist for effective intervention;

for the purpose of providing a comprehensive planning and approach to provision of the Mental Health Care Delivery System.

Recommendation # 25

RECRUITMENT OF REHABILITATION STAFF

That: aggresive recruitment efforts be instituted to staff existing rehabilitation vacancies.

Recommendation # 26

REVIEW OF PAY LEVEL CLASSIFICATION

That: the present pay classification standards for rehabilitation staff be reviewed to ensure that well qualified personnel can be attracted in the current time of manpower shortage across the country.

Recommendation # 27

EXPANSION OF REHABILITATION SERVICES

That: exiting specialized rehabilitation services (Audiology, Occupational Therapy, Physiotherapy, and Speech Therapy) be expanded to under serviced regions.

Recommendation # 28

That: rehabilitation services be expanded to include rehabilitation programs for home care and long term care.

Recommendation # 29

ESTABLISHMENT OF LEVEL 5 BEDS IN THE N.W.T.

That: consideration be given to establishing Level 5 (Rehabilitation) Beds in the N.W.T.

Recommendation # 30

EARLY INTERVENTION PROGRAMS

That: the mandate for "early intervention programs" be established and funded, and that services be available to all regions.

Recommendation # 31

COMMUNITY HEALTH REPRESENTATIVES (CHR)

That: priority be given to filling of current vacant CHR positions.

Recommendation # 32

ESTABLISHMENT OF CHR'S IN EVERY COMMUNITY

That: CHR positions be established in every community.

Recommendation # 33

CHR TRAINING PROGRAM IN THE N.W.T.

That: a training program for CHRs be developed and implemented in the NWT.

Recommendation # 34

MULTIDISCIPLINARY CLIENT ASSESSMENT UNIT PROGRAMS

That: where possible regional multidisciplinary assessment programs be developed.

Recommendation # 35

ADULT DAY CARE

That: priority be given to the development and funding of adult day care programs operated as a component of personal care/ long-term care programing.

Recommendation # 36

RESPITE CARE

That: community and facility based respite care programs be developed and funded.

Recommendation # 37

FOSTER FAMILY CARE

That: where feasible, foster family care be expanded to accommodate the needs of aged and chronically ill persons.

Recommendation # 38

ELDER ABUSE

That: The phenomenon of elder abuse(s) in the N.W.T. be explored in depth.

Recommendation # 39

INSTITUTIONAL CARE

That: the Departments of Health and Social Services construct and operate facilities where indicated by the survey of needs.
[Note: This could be accomplished directly by Government operating the facility or by contract arrangement with a non-profit society eg. new Yellowknife Personal Care Home)]

Recommendation # 40

VISITATION TRAVEL BENEFITS FOR PERSONS IN INSTITUTIONAL CARE AND FAMILY MEMBERS.

THAT: A visitation travel benefits policy be developed and funded for persons in institutional care and their families where clients are institutionalized outside their home community.

Recommendation # 41

REPATRIATION OF CLIENTS

THAT: an in depth review/assessment of N.W.T. residents currently placed in southern facilities be conducted, and that a comprehensive action plan be developed regarding possible repatriation.

Recommendation # 42

ORGANIZING THE CONTINUUM OF CARE

That: the proposed overall coordinated approach to the Continuum of Care be further developed and adopted by the Departments of Health and Social Services in cooperation with other agencies.

Recommendation # 43

LEGISLATIVE MANDATE

That: a legislative mandate be developed to ensure adequate funding for the Continuum of Care has a high priority.

Recommendation # 44

ESTABLISHMENT OF ONE SYSTEM

That: a system be developed and implemented to co-ordinate the provision of all non-institutional and institutional continuing care services including Home care Programs, Senior Citizen Housing, Personal Care Homes, Long Term Care Facilities and clients in hospitals.

Recommendation # 45

ESTABLISHMENT OF DIVISION OF COMMUNITY & CONTINUING CARE

That: a division of Community and Continuing Care be established as a division of the Department of Health to facilitate and co-ordinate the overall planning, development and evaluation of programs and services to ensure the Continuum of Care.

Recommendation # 46

DIVISIONS RESPONSIBILITY

That: the division be responsible for: financial accountability; assessment and placement; travelling rehabilitation services; and consulting professionals.

Recommendation # 47

ESTABLISHMENT OF REGIONAL OFFICES

That: Regional offices of the division of Community and Continuing Care be established to be responsible for management and co-ordination at the regional and community level. [Note: Where Regional Health Boards exist, they should be mandated with the responsibility for recommendations # 47 and 48.]

Recommendation # 48

ENSURING REGIONAL INPUT

That: Regional Community and Continuing Care Advisory Committees be established to ensure Interagency co-operation and co-ordination and that Regional concerns are addressed.

Recommendation # 49

PROVISION OF COMMUNITY ORGANIZATION AND LEADERSHIP

That: community leaders provide leadership and direction by giving priority to establishing Community Health and Social Services planning committees to:

1. provide local input and decision making in the co-ordination of existing Health and Social Services Programs.
2. consider unmet needs, and
3. provide for future planning.

Recommendation # 50

THE APPROACH TO COMMUNITY SERVICES

That: the philosophy of joint Health and Social Service Center be adopted to formally link and provide community programs and services.

Recommendation # 51

PHYSICAL HOUSING OF PROGRAM STAFF

That: the feasibility of uniting community Health and Social Services staff under one roof be examined.

Recommendation # 52

MANAGEMENT AND CLIENT INFORMATION SYSTEM

That: a methodology be developed to store, maintain, manipulate and constantly update the information gathered by the Assessment Project for planning, development and delivery of effective programs and services.

Recommendation # 53

That: if the proposed system is not implemented, consideration be given to scheduling a repeat Assessment project in five (5) years time.

Recommendation # 54

REVISIONS TO CURRENT ASSESSMENT TOOLS

That: existing forms and brochures be reviewed and revised with clarified terminology prior to next reprint.

Recommendation # 55

That: forms be distributed with an explanation of proper completion for reference.

Recommendation # 56

INTER-AGENCY RELATIONSHIPS AND COMMUNICATIONS

That: G.N.W.T.- Health, G.N.W.T.- Social Services, G.N.W.T.-Education, Health and Welfare Canada, and the N.W.T. Hospital's Association develop a joint, workable, clear and detailed policy on the mutual sharing and release of information that can be implemented by workers at the community level.

Recommendation # 57

TRANSLATION OF INFORMATION

That: the next revision and printing of information concerning "Services to the Aged and Disabled" and other program brochures be translated and available in print or on audio cassette.

Recommendation # 58

LEVELS OF CARE

That: the Departments of Health and Social Services review and redefine the existing levels of care and expand these to include consideration of community based care for Levels 2 and 3.

Recommendation # 59

COMMUNITY VISITS

That: priority be given to visiting communities for which no assessment information is available.

Section 2

The Project

2.0 THE PROJECT

2.1 PURPOSE OF THE PROJECT

In the Northwest Territories, as in the rest of Canada, the population of elderly is growing in proportion to the rest of the population. The roles of the elderly in the extended family are changing. As a result, there is an increasing demand for care for aged, disabled and chronically ill to both the Department of Health (Health) and the Department of Social Services (Social Services) For population projections see demographic information in Section 4.3.

In order to plan programs and services for the aged, disabled, and chronically ill, there is a requirement to know and project the present and long-term needs on a community by community, region by region basis. Information that has been available to date has been sparse and existed for only a few communities. The lack of an overall perspective would, it was felt, result in potentially inappropriate or untimely programs and services being developed.

In keeping with the Territorial Government's priority to promote healthy life styles, and because there are particular concerns for aged, disabled and chronically ill persons, a territory-wide Assessment Project was implemented to:

1. obtain baseline data identifying the needs of these persons in relation to the existing recognized levels of care;

2. identify support services, programs and facilities already present in the community, those being planned by the community and the potential for the community to provide certain services in the future;

3. collect and update information on Northerners who are in the care of institutions in southern Canada;

4. provide some "in-service" training/assistance for local personnel (e.g. nurses and social workers) in their particular community as to the completion of the Assessment and Placement Record and the procedures to follow when service is required;

5. assist in developing a plan to address current and future needs for programs and services to maintain personal independence.

People have expressed the need to remain independent and in their own homes as long as possible, and with respect to programs and services, the philosophy of the Government of the NWT reflects that need for persons to maintain independence.

The word "health" (in the context of this report) refers to the optimum functioning of an individual - physically, mentally and socially. Health and Social Services believe that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every NWT resident without distinction of race, religion, sex, political belief, location, economic or social condition. Therefore, health is viewed as a partnership involving personal responsibility of individuals in conjunction with supportive programs and services provided by government.

As this study is reviewed in detail and as decisions are made, it follows that long-range plans will be affected. This report represents the objective findings of the Project Officers during the 85/86 assessment period. The recommendations made are based on those observations. The report must be looked at as an informational document reflecting this specific timeframe.

Thus, as months and years go by, and clients and community resources change, updated information will be required to complement this report.

2.2 FUNDING FOR PROJECT

Priority funding was approved by the Executive Council in the amount of $100,000 for the 1985/86 fiscal year to employ two (2) Assessment Project Officers (Project Officers) and to pay for travel and related project costs.

An extension of the project and additional funding of $45,000 was necessitated because:

- of travel occurring late in the year when weather has a significant impact on travel and the impossibility of continuing with a pre-determined schedule,
- the actual planning of visits to all communities presented more complexities than was initially projected,
- one of the Project Officers undertaking additional responsibilities for the start up of the Inuvik Long-term Care Facility.

Total funding allocation for the project: $145,000.

2.2 RESPONSIBILITY & REPORTING

Project Officers were employed as members of the Department of Health, Programs & Standards Division. They reported to the Program Policy Officer responsible for Long-term Care Programs.

As this was a joint project with the Department of Social Services, project staff also reported to the Co-ordinator for Aged & Handicapped Services.

Initial and ongoing project "team" meetings and discussions were held throughout the length of the project for advice and direction.

2.4 ACKNOWLEDGEMENTS

A number of persons were involved with the preparation of this report. Appreciation is expressed in particular to the following:

Elaine Berthelet, Chief, Health Programs and Standards, Department of Health;

Bronwyn Watters, Chief, Social Service Programs, Department of Social Services;

Pat Felhaver, Co-ordinator, Aged and Handicapped Services, Department of Social Services;

Margaret Marshall, Program Policy Officer, Health Programs and Standards, Department of Health;

for their guidance and assistance throughout the course of preparing this report.

Appreciation is also extended to:

Headquarters and Regional Staff Officials from the Department of Health and the Department of Social Services;

Headquarters and Zone Staff Officials from Health and Welfare Canada;

Registered nurses, community Social Services workers, Community Health Representatives and Homecare Co-ordinators;

Community Council and Health Committee representatives;

who provided us their time, information concerning clients and community knowledge.

Section 3

METHODOLOGY

2.0 METHODS

2.1 REVIEW OF EXISTING PROGRAMS & SERVICES

In preparation for conducting the Assessment Project, there was a need for Project Officers to become familiar with existing programs and services available to clients. This information is summarized in Appendix 1, the booklet entitled "Services to the Aged & Disabled".

2.2 THE ASSESSMENT AND PLACEMENT TOOLS

The Assessment and Placement (A&P) Record, Appendix 2, also called the "green form", was used whenever possible to collect information about the health and social situation of disabled clients. The Project Officers interviewed the clients themselves as often as possible to complete the A&P Record. It was not practical to visit every aged, disabled and chronically ill person personally, therefore, information was collected from people in the community who knew the clients by virtue of their professional helping relationship. Thus, community social workers and nurses provided much of the information the Project Officers needed.

The A&P Record was revised in 1984 for use with disabled and elderly people. The record is familiar to Home Care Coordinators. However, in the smaller communities, where there is no Coordinated Home Care Program and where the Social Services workers are not familiar with nursing terminology, the Project Officers first translated the questions on the A&P Record into clearer English. For example, they substituted the term "wets the bed (or himself)" for "incontinent of urine", "teeth" for "dentition" and so on.

2.3 VISITS TO THE COMMUNITIES

The two Project Officers visited thirty-four communities between October 1985 and July 1986. To ensure reliability, a general pattern was established. In October 1985, letters were sent to all the regional directors, the chairmen of local governments and the presidents of native organizations. Separate letters were sent by the Project Officers to the nurses in charge and to Social Service workers in all the communities where visits were planned. The letters introduced the project and the Project Officers. Several neighboring communities were usually included in each trip. Before departing on each trip, the Project Officers made telephone calls to the nurses, Social Service workers, and band or hamlet officials, informing them of the planned visits. The Project Officers tried to schedule visits when everyone was available, however, given the time constraints of the project and the extensive travel by other personnel, this was not always possible.

When a Project Officer arrived in the communities, a meeting was held with the nurse in charge and the Social Services workers, and where possible with Hamlet councils, elders' councils, Social Services affairs and health committees. At these meetings, the Project Officers introduced the project and answered questions. They tried to stimulate constructive thinking about the needs of the elderly and handicapped, and to provide information about government programs and policies when needed. Copies of the booklet, Services to the Aged and Disabled, were left with individuals and groups who showed a particular interest in developing services for their communities.

In meetings with the nurses and the Social Services workers, and in some cases with the Community Health Representatives, the Project Officers established lists of all the disabled and chronically ill in the community, their condition and level of function and their placement situation. The Project Officers tried, in conversation with the informants, to establish a level of care (discussed in more detail below) for each client. In some cases, they went through the records for each client with the informants, discussing and completing the records. This informal, "in-service" education was intended to familiarize workers in the communities with the A&P Records presently in use by Health and Social Services so that in future the workers could complete the records themselves.

When time and circumstance permitted, the Project Officers visited clients in their homes, schools and at gathering places. A particular effort was made to see clients at level 2 and higher. When they visited clients, they assessed their disabilities, noted necessary home renovations, corrected exercise routines, offered suggestions for self-help devices and the like.

In communities where few clients spoke English, interpreters were hired. These interpreters were helpful not only in translation, but also in understanding the cultural variation in attitudes and concerns encountered. Interpreters who knew the communities also helped the Project Officers find their way to the clients' houses through the snowdrifts and other obstacles.

In some communities, weather conditions prevented visiting clients' homes and the Project Officers had to rely entirely on information from community professionals.

3.4 LEVELS OF CARE AND TERMINOLOGY

3.4.1 The levels of care:

The Aged, Disabled and Chronically Ill Assessment Project used the system of patient classification that was already in use by Health and Social Services. This system, which is a categorical scale with numerical labels, is used by the departments to assist with placement of clients. It is also used to decide

which of them has funding responsibility for individual clients. The Department of Social Services assumes responsibility for all those clients who are assessed as level 1 or 2. Health assumes responsibility for all those clients who require nursing or medical care; levels 3, 4, 5 and 6. See Appendix 6 for the official definitions for each level.

3.4.2 Interpretation of the levels:

As the Project Officers became familiar with the levels, they could quickly assign clients to the appropriate categories. The first assessments were done together, then results were compared to ensure inter-rater reliability. It was found that confusion may arise at first when raters start using the A&P Record. There is a tendency to regard the system of levels as an ordinal or interval scale, because of the numbers, with one level "better" (or worse off if you will) than the other. After discussing these differences, the Project Officers found that looking at the definitions of the levels for the best descriptions of the clients' situation was the best way to increase their agreement.

3.4.3 Examples of interpreting the levels:

The Project Officers agreed that if the client needed help from another person with heavy housework or laundry, for example, they belonged in level 2. Similarly, if clients required outside help, such as fetching and cutting wood to heat their homes, they were level 2. If their families were doing the heavy work for them, this was noted, but the client was still level 2.

If the client required a lot of nursing care, but it was routine and could be accomplished by an aide or attendant, that client was assigned to level 3. If, for example, a client had to be checked often by a nurse because of frequent changes in response to medication or if a client had a tendency to choke while being spoon fed, and thus required suctioning, he/she was assigned to level 4.

3.4.4 Other definitions:

Other definitions such as "aged", "senior citizen", "at risk" and "handicapped", which were less crucial to the project than the definitions of levels, caused some confusion among workers in the communities. The Project Officers explained each definition as the problems came up. A list of the most commonly explained definitions appears in the glossary. (Section 8)

3.5 COMMUNITY PROFILES

Information about the resources and services available in the community was collected by the Project Officers on forms called Community Profiles (Appendix 7.4). Usually the Project Officers obtained the information by walking around the community and observing access to buildings and the like, but occasionally

others, such as Hamlet Secretary Managers, completed parts of the Community Profiles. The Project Officers asked the nurse in charge about the nursing station and services; information about homemaker programs and neighborhood services was obtained from the Social Services workers. In some of the communities with Coordinated Home Care Programs, the Home Care Coordinator completed the Community Profile.

2.6 RECORD ASSEMBLY AND DOCUMENT HANDLING

As soon as possible after each community visit, information about clients' condition/disability, placement situation, level of care and miscellaneous comments were entered onto a Confidential Client Summary sheet (Sample - See Appendix 5). A&P Records that had been completed were filed in project files in Health and are accessible to Social Services. Where there was an existing Co-ordinated Homecare Program, A&P Records were left with the Co-ordinator. This report, therefore, is assembled from all of the above-mentioned data.

Section 4

FINDINGS OF PROJECT STAFF

BY REGION BY COMMUNITY

4.0 FINDINGS OF PROJECT STAFF BY REGION, BY COMMUNITY.

4.1 Explanation of Community Profile and Format

The communities of the Northwest Territories are diverse and spread over many miles. They have many differences yet much in common. The purpose of this foreword is to outline areas of commonality so that as a reader goes through the community report areas of difference will stand out clearly.

The format is:

DEMOGRAPHY:

In this section the figures quoted are from the document entitled "Preliminary Population Projections" - base year June 1985. Produced May 8,1986 by the GNWT Bureau of Statistics.)

TABLE OF LEVELS BY AGE GROUP:

This table summarizes the number of clients, as at May 1986, living in the community found to be at various levels of care/ need in the particular community at the time of the Assessment Officer's visit.

In the column labeled "FUTURE" the Project Officers have attempted to project the number of persons who may need care of some description in the near future (within the next 5 years). As well, there will likely be progression within the levels (Eg. L1 to L2 or L2 to L3).

Number of people placed "in care" outside the community:

In this section, information is provided on the numbers of persons from the particular community who have been placed outside their home community for care not available locally. These persons may have been placed elsewhere within their region, within the NWT, or in southern facilities depending on their particular needs. A detailed confidential client listing has been developed to which the appropriate authority can refer for this information.

COMMUNITY RESOURCES:

Hospital:
This section provides information on the nearest available hospital facility (and for some communities, alternate existing arrangements) on which the community can rely for medical backup.

Nursing station:
This section outlines the rated bed capacity for the particular community nursing station and outlines the staffing at time of survey.

Home nursing:
In most communities no Home Nursing Program exists. The Nurses from the nursing station may try to make periodic home visits to clients too sick to come to the nursing station (e.g. a terminally ill client), however, the general policy of Health & Welfare is that people must come to the station with injured/ill people as there are heavy time constraints on the nurses and they do not have time to make regular home visits part of their routine.

In a one (1) nurse station, the nurse usually does not have the time to make home visits as this would leave the station unattended.

Homemaker services:
Most Homemaker service programs have been started within the past 2-3 years. The service may be operated by the local Social Services office directly or may be operated by contract arrangements between Social Services and a responsible party (eg. Community council). Homemakers provide services such as: household cleanup, laundry, meal preparation, personal bathing, and childcare. There currently is no training program nor are there specific guidelines for homemakers. It is therefore difficult for both the homemakers doing the work and their supervisor to know whether or not they are performing the work satisfactorily.

Equipment loan: Medical Services or the local Hospital provide a limited number of small items such as bedpans, urinals, canes, and crutches. Other equipment can be obtained through the Zone Office. As well where equipment is to be used on a long-term basis, purchase may be covered by Health & Welfare Canada, Medical Services; the Department of Social Services; the Department of Health (Extended Medical Benefits); the Worker's Compensation Board or a private insurance plan (eg. G.S.M.I.P.) depending on the particular person's eligibility. If the person is not eligible for this benefit, he/she would be responsible for the purchase.

Meals on wheels: This service is not available in most communities and for the most part may not be culturally appropriate in many smaller communities. Many clients prefer country food, which is usually shared. Where there are younger men who are involved in wage labor, often they do not have enough time to hunt to provide for all the needs in the community. Most often family or visitors prepare food for someone who is not able to prepare it themselves. It was noted that most families look after their elderly and disabled within the family. When this does not happen homemakers are needed to prepare meals.

NEIGHBOURHOOD SERVICES:

Handyman/labor:
Most houses are operated by the Housing Association, thus necessary maintenance is handled by the Association. Others owning their homes can usually find local workers able to assist. For the most part, shovelling snow and carrying heavy loads of groceries etc. is handled by family members and friends.

Friendly visiting:
Most communities are small enough that everyone knows everyone and therefore there is awareness of the need (or not) to visit. Visiting of family and friends occurs in the natural course of the day's events, and everyone who is able visits. In some communities, the women of the local churches have seen a particular need and do go in regularly to visit elderly and shutins. When family members or others who are living with an elder or disabled person go off to school, hunting, or jobs, these persons may be left alone and unattended. Where this occurs, homemaker services are needed not only to provide for cooking and cleaning, but also to provide companionship and supervision.

Errand running:
Usually provided by family and/or friends.

Transportation:
In this section we specify the commercial transportation arrangements (if any) available in the community. It is also noted that there are both private and government (local, Territorial or Federal) vehicles available that may from time to time serve as transport. The majority of vehicles are not equipped with any features to make them accessible for use by disabled persons.

Respite care:
There is a fairly strong tradition of "caring for our own" in many of the communities. Many families care for disabled or terminally ill persons in their own homes. To assist the family unit and client it is important to provide "respite" (relief) for the family so that they can continue to provide care while still having some freedom to get out of the house and attend to other matters knowing that the client is being adequately cared for while they are absent.

Coordinated Home Care:
To date, this program has only been developed in the communities of Ft.Smith, Hay River, Inuvik, and Yellowknife. The program provides health and support services to the elderly, chronically ill, and disabled to allow them to remain in their own homes. These services include those provided by nurses, homemakers, and to the extent that they are available, Physiotherapists, Occupational Therapists, Speech Therapists, Audiologists, and Nutritionists. As well, the program assists families in times of crisis, and in some instances, allows for early hospital discharge. In other communities no such program exists. In many there is no concept of such a program, however, the need still exists for the provision of Home Nursing care.

Physical facilities:
This section describes what (if any) other Health or Social Services facilities are available in the particular community.

Human resources:
This section describes what other (if any) Health or Social Services personnel are available and unemployed in the community who may be available if needed.

OTHER CONSIDERATIONS:

1. **HOUSING:**
A pressing need exists in most communities for more and adequate housing units. In many housing units there are more than one family and this results in overcrowded conditions putting undue stress on the family unit.
The Task Force Report on Housing provides much specific detail of the concerns that need to be addressed.
Particular needs observed by the Project Officers included:
  a.repairs and renovations to make units warm and comfortable.
  b.need for funding for renovations to provide better accessibility eg. ramps to replace steep steps; bathroom facilities at floor level rather than having to climb 5 or 6 steps;
  c.funding for renovations to provide grab safety bars beside toilets and for tubs in homes where these are needed.

2. **COMMUNITY ACCESS:**
In most communities, little has been done to consider access for disabled or infirmed persons. In most areas, construction must be done in such a way as not to melt the permafrost subsurface and/or accommodate the lay of the land. As a result, most buildings have several steps. Some buildings have handrails but many do not. Few buildings have been constructed with ramp access. Some have ramps that do not meet the door sills. This makes normal access impossible for a wheelchair client, and difficult at best for a client on crutches or with a cane.

3. ALCOHOL & DRUG ABUSE:
In this section we indicate whether or not a community has implemented Community Controls / Prohibition. Alcohol & Drug Education Committee programs are noted where they are available to residents of the community.

4. COMMUNITY HEALTH REPRESENTATIVES:
In communities where there is a C.H.R., (Community Health Representative) the C.H.R. makes home visits to elders, disabled and chronically ill to teach and demonstrate family health care and to monitor and refer medical health problems to the nurse in charge. At the same time, the C.H.R. provides company and visiting which is so necessary to the welfare of the elderly.
The C.H.R. is not trained to provide Nursing care, however the work of the C.H.R. does assist the Nurse and may allow more time for other priorities in care.

COMMUNITY NAME

REGION

DEMOGRAPHY

Projected population total:

Elderly	65 and over
Working age	15-64 years
Youngsters	under 14

****

TABLE OF LEVELS BY AGE GROUP

	Future	Level 1	Level 2	Level 3	Level 4
Elderly (65+)					
Working age (15 - 64)					
Youngsters (to age 14)					
TOTALS:					

****

Number of people placed "in care" outside the community:

RESOURCES

Hospital: Closest hospital facility is

Nursing Station: Bed rating: Three (3) beds
One (1) bassinet

Staffing: Two (2) R.N.'s
One (1) Clerk /Interpreter *
One (1) Housekeeper *
One (1) Janitor *
* Part time

Home nursing:

Homemaker services:

Equipment loan:

Meals on wheels:

Neighborhood services:

Handyman/labor:

Friendly visiting:

Errand running:

Transportation:

Respite care:

Coordinated Home Care:

Physical facilities:

Human Resources:

MISCELLANEOUS CONSIDERATIONS

1. ALCOHOL & DRUG ABUSE:

2. COMMUNITY ACCESSIBILITY:

TABLES (Edited)

Please note: The number of clients reported includes only clients living in the community and does not include persons in Health Care Facilities

Regional summary of clients

Table # 1 -Baffin Region

Table # 5 -Ft. Smith Region

Table # 9 -Inuvik Region

Table # 13 -Keewatin Region

Table # 17 -Kitikmeot Region

Summary by age, by region by levels of care-

Tables # 21,22, & 23

Territorial Summary

Tables #24 & 25

4.3 DEMOGRAPHIC CONSIDERATIONS

Aged, disabled & chronically ill citizens in the Northwest Territories, as in the rest of Canada, are living longer and making greater demands on society. Advances in medicine and technology have increased the life expectancy of the population and at the same time the need and demands for programs and services for this segment of the population have increased.

Age projections for the future are as follows:

NWT POPULATION PROJECTIONS BY AGE GROUP

Year Group	1981*	1986**	1991**	1996**	2001**
65+	1,295	1,463	1,940	2,499	3,129
15-64	28,370	32,752	35,681	38,704	42,807
0-14	15,870	17,849	19,366	20,858	21,803
TOTAL	45,535	52,064	56,987	62,061	67,019

Key: * = Census Data
** = Projections

Source: GNWT Bureau of Statistics

Notes:

1. Estimated population as of May 1986 was 52,064 of which 2.8% (1463) are 65+.

2. A further breakdown of the elderly (65+) for 1986 by ethnic background indicates that 41% are Dene, 33% Inuit and 25% represents other groups. By 2001 it is projected that there will be a shift as follows: 31% Dene/Metis, 33% Inuit and 36% others.

3. The projected increases in the 65+ group from 1981 census to 2001 projection is for a 242% increase. A breakdown by 5 year periods is as follows:

   From 1986-1991 projected increase in 65+: 133%
   From 1991-1996 projected increase in 65+: 129%
   From 1996-2001 projected increase in 65+: 125%

TABLE # 1

REGIONAL SUMMARY OF CLIENTS BY AGE GROUP, BY LEVELS OF CARE

BAFFIN REGION

Age Group	Future	Level 1	Level 2	Level 3	Level 4
Elderly (65+) (65+)	22	18	14	3	0
Working Age (15-64)	48	48	19	4	1
Youngsters (0-14)	7	14	9	6	1
Totals	77	80	42	13	2

The Northwest Territories Administrative Regions

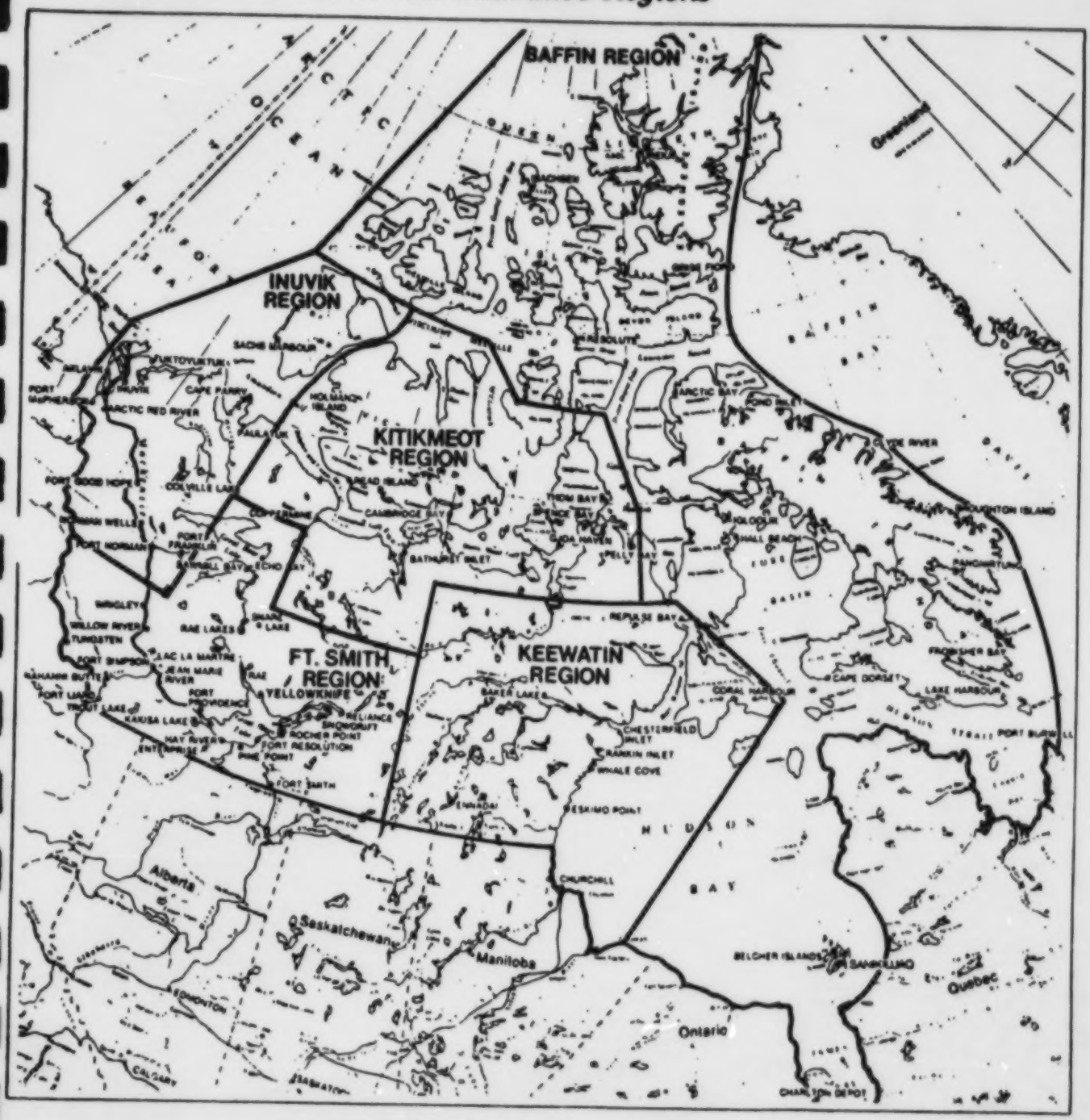


TABLE # 5

REGIONAL SUMMARY OF CLIENTS BY AGE GROUP, BY LEVELS OF CARE

FT. SMITH REGION

Age Group	Future	Level 1	Level 2	Level 3	Level 4
Elderly (65+) (65+)	61	116	64	18	2
Working Age (15-64)	36	39	28	2	1
Youngsters (0-14)	3	2	8	4	2
Totals	100	157	100	24	5

TABLE # 9

REGIONAL SUMMARY OF CLIENTS BY AGE GROUP, BY LEVELS OF CARE

INUVIK REGION

Age Group	Future	Level 1	Level 2	Level 3	Level 4
Elderly (65+) (65+)	23	61	43	10	3
Working Age (15-64)	37	44	7	1	1
Youngsters (0-14)	13	7	2	1	0
Totals	73	112	52	12	4

TABLE # 13

REGIONAL SUMMARY OF CLIENTS BY AGE GROUP, BY LEVELS OF CARE

KEEWATIN REGION

Age Group	Future	Level 1	Level 2	Level 3	Level 4
Elderly (65+) (65+)	7	11	29	4	0
Working Age (15-64)	17	24	26	3	1
Youngsters (0-14)	6	6	6	4	0
Totals	30	41	61	11	1

TABLE # 17

REGIONAL SUMMARY OF CLIENTS BY AGE GROUP, BY LEVELS OF CARE

KITIKMEOT REGION

Age Group	Future	Level 1	Level 2	Level 3	Level 4
Elderly (65+) (65+)	25	6	6	1	0
Working Age (15-64)	14	8	8	0	0
Youngsters (0-14)	0	7	3	2	0
Totals	39	21	17	3	0

TABLE # 21

CLIENTS 65+ BY REGION, BY LEVELS OF CARE

REGION	Future	Level 1	Level 2	Level 3	Level 4
BAFFIN	22	18	14	3	0
FORT SMITH	61	116	64	18	2
INUVIK	23	61	43	10	3
KEEWATIN	7	11	29	4	0
KITIKMEOT	25	6	6	1	0
Totals	138	212	156	36	5

TABLE # 22

CLIENTS 15 - 64 BY REGION, BY LEVELS OF CARE

REGION	Future	Level 1	Level 2	Level 3	Level 4
BAFFIN	48	48	19	4	1
FORT SMITH	36	39	28	2	1
INUVIK	37	44	7	1	1
KEEWATIN	17	24	26	3	1
KITIKMEOT	14	8	8	0	0
Totals	152	163	88	10	4

TABLE # 23

CLIENTS 0 - 14 BY REGION, BY LEVELS OF CARE

REGION	Future	Level 1	Level 2	Level 3	Level 4
BAFFIN	7	14	9	6	1
FORT SMITH	3	2	8	4	2
INUVIK	13	7	2	1	0
KEEWATIN	6	6	6	4	0
KITIKMEOT	0	7	3	2	0
Totals	29	36	28	17	3

TABLE # 24

TERRITORIAL SUMMARY

CLIENTS BY AGE GROUP, BY LEVELS OF CARE

Age Group	Future	Level 1	Level 2	Level 3	Level 4	Total
Elderly (65+)	138	212	156	36	5	547
Working Age (15-64)	152	163	88	10	4	417
Youngsters (0-14)	29	36	28	17	3	113
Totals	319	411	272	63	12	1077

Table # 25
CLIENTS BY AGE GROUP, BY NUMBERS OF CLIENTS, BY % OF TOTAL CLIENTS

Age Group	# of Clients	% of total clients
65 +	547	51 %
15 - 64	417	39 %
0 - 14	113	10 %
	1077	100 %

Section 5

DISCUSSION

AND

RECOMMENDATIONS

Section 5 - DISCUSSION & RECOMMENDATIONS:

5.1 GENERAL DISCUSSION

This section of the report will present the recommendations arising from the analysis of available data. Each recommendation will stand alone with general discussion of the supporting rationale.

The Northwest Territories is wonderfully varied in its communities and its people. No two communities are the same, a fact that complicated the project officer's task of analysis. Many differences exist. The Dene communities generally have band councils who take on contracts for homemaking, wood-cutting, and the like. Inuit communities don't have to cut wood! Many services for the Inuit are organized by committees of local government and by their church groups. For them it is relatives, neighbors and friends who bear the major responsibility and work of looking after the disabled, infirm, and chronically ill in their communities. Families in the eastern N.W.T. do not seem as willing to accept the assistance of support services such as homemakers as families of the western N.W.T. These functions are regarded as part of the family's duty, and there is a certain loss of esteem when support services are utilized.

Wage labour has been available to people living along the MacKenzie River system for far longer than it has been for most of the Eastern Arctic. Many Western arctic people have adapted their lifestyles, their aspirations, and their possessions to the wage system and to the income and demands it produces. In some cases, individuals have been requesting to be paid to care for their parents. There are more requests for senior citizens' housing units and personal care facilities. Although the N.W.T. has not considered wages for housework, requests to be paid for homemaking services should not be dismissed, but be recognized for what they are: statements about the economic facts of life.

It is expected that the changes the west has seen in the last century will occur in the east within the next 20 to 30 years. Community representatives from the Eastern Arctic have developed a thriving co-operative system. They, like the Dene, are engaged in land claim negotiations, and are considering petroleum and other resource development. Soon they will need supplements to kin and informal support, respite care such as home care, seniors' homes, and long term care facilities. The detail varies, but the effect development has on people's lives is the same.

Certain problems have been noted repeatedly in community summaries: the shortage of Nursing staff for home visits and home care, the inaccessibility of most public buildings, the number of people who are in southern facilities because there is nothing for them here in the N.W.T., and especially the family involvement in providing food, housework, company, heavy chores, and all manner of support. All of these factors must be borne in mind when considering what to plan and develop in the future.

Project officers were confronted with issues which do not appear clearly in any of the community summaries, but which certainly influence future direction.

The generation gap is as apparent in the Northwest Territories as it is in any other culture or historic period. Some people who are over 65, have lived traditional lifestyles on the land hunting, fishing, trapping, sewing their own clothes, and keeping house in simple shelters with few material possessions. Younger people have been to school, have paying jobs some of the time and accumulate material possessions. They also have less time to learn and practice traditional living skills. The elders speak native languages and a smattering of English; the middle generation speak both languages but are comfortable with English, and children speak mostly English. Younger people, who still show great respect for their elders, often say the elders just don't understand. However, mutual respect is usually there; people of all ages do try to talk and listen to each other.

It is important not to long for the good old days when life always ran smoothly and was better. The evidence is that it never did. People lived in igloos and tents. Sometimes they were cold, sometimes they were hungry, sometimes they starved to death. People helped their relatives, as they do today, as much as possible. But average people died young, and chronically ill did not survive. Taking care of disabled or infirm people was not as hard as it is today; nor did it go on for so long.

People in communities are generally doing an excellent job of caring for their elderly, disabled, and chronically ill. At times, alcohol, wage work, poverty, and depression interfere, but in most cases someone in the community makes sure the people in the community who need care get it. Elders, social service committees, nurses, and social service workers, could always tell the project officers who should be taking care of whom, and whether they were. However, families need respite from the constant care and responsibility, they need help with the physical and financial burden of long term home care, and they may need training to carry out various home procedures. Staying home to care for a sick, infirm, or disabled relative does reduce the caregiver's potential income, limit the caregiver's freedom to participate in living on the land and recreation, and creates extra heavy work.
Families are reluctant to put old people in hospitals outside their community even when it appears institutional care is the best choice. A number of the recommendations that follow relate directly to this important issue.

Elders who have families living in the same communities are fortunate. They are also in the majority. However, there is a visible minority of single elderly men. Many of these fellows were prospectors and miners (presently living in the communities of Ft. Smith, Hay River, and Yellowknife, who came north during the gold rush of the forties. They have lived independently most of their lives. Now many are too old and frail to live by themselves. They have no relatives to care for them; they must be housed in senior citizens homes and cared for by Co-

ordinated home care programs. There will always be some people like these in the North, and they will always create special needs which impact on the health and social services systems.

Better transportation services and more social activities were recognized as needs in many communities. Community representatives indicated that it is imperative that elders are not segregated to one corner and ignored. The elders' feelings of self worth must be maintained. Several communities had facilities (community halls) that were under-utilized during the day that could have been used as gathering places. Some community involvement is seen as necessary to keep social functions for the elderly viable.

Since many cultures comprise the Arctic community, it is important to consider the way traditional values influence views relating to modern health care.

The aged, disabled, and chronically ill population will increase dramatically over the next 10 to 20 years. Demands for services will be increasing as their needs increase. Planning must commence now in order to provide adequately for the future. The recommendations which follow attempt to outline ways and means of maintaining people with independence and dignity.

5.2 PHILOSOPHY FOR PROGRAMS AND SERVICES

Recommendation # 1

That: the G.N.W.T. Departments of Health and Social Services adopt the following philosophy for provision of care programs and services being provided to N.W.T. residents.

THE INDIVIDUAL

The care of the aged, disabled & chronically ill must be based on respect for the individual as an independent member of society who has the right to make decisions about his/her life and to function with those choices in as normal a setting as possible. For most, this can best be achieved through care services provided in the home.

Individuals should not be institutionalized until all other avenues of care have been explored and deemed inappropriate.

HOME CARE PROGRAMS

Home care programs need to be founded on the following beliefs:

- Individuals can usually retain greater independence and have more control over their lives in their own homes rather than in a long-term care facility or other institution.
- Most individuals prefer to remain at home and to receive any required services at home.
- Existing support provided by families and friends should be preserved and, if necessary, supplemented with respite care.
- Services should be provided to assist individuals to retain (maximum) independence at home, but the provision of services is not intended to create unnecessary dependencies in individuals nor to replace assistance usually provided by the family or community.
- Individuals requiring home care services should participate in identifying their need , establishing goals for services provided and developing plans to meet the goals.
- Home care programs must respect the right of the individual to accept or refuse any services recommended after assessment.
- The need for home care services can be met most effectively if significant responsibility for planning and delivery of services is exercised at the local level.
- There is a responsibility to promote the participation of volunteers.
- We should be continually seeking new ways and means of responding to identified needs in the communities.

INSTITUTIONAL CARE

Institutional care needs to be founded on the understanding that:

Even when institutionalized, the individual must continue to retain the right to privacy and to remain independent in every way possible. This requires that the institutional setting be developed from a medical-custodial model toward a social-developmental model. This change should be reflected in continuing care and should emphasize personal dignity and independence, and encourage maintenance of the person at his/her level of care together with rehabilitation, remotivation and enrichment of the whole person.

The philosophy that a personal care home or long-term care facility should be a "home away from home" is admittedly difficult to achieve, but not impossible. There must be flexibility in schedules of facilities that allow a resident to make choices about their daily living situations. Each resident's room should lend itself to individuality and to privacy to such an extent that visitors will see a reflection of the individual "at home" in that room.

While the individual is receiving long-term care, relatives should be encouraged to maintain supportive family ties. Residents should be provided with a social network in the institution that is conducive to individual well-being. The resident should have access to a private area where he/she is able to continue personal relationships with family and friends. Along with the privilege of placing a family member in continuing care facilities, family and friends have a responsibility of giving support and affection to that individual.

Each person receiving any type of continuing care has the right to a high calibre of service by trained staff. Staff education is a high priority and must include understanding of how to help, comfort and alleviate pain and distress of clients and families as well as to treat their disabilities whether they receive care at home or in an institution.

Even though the later years may in some cases bring physical and social stress, this part of life still remains a time of growth and self-realization. These positive aspects of aging need to be emphasized by programs and policies encouraging the input of those receiving continuing care.

CONTINUUM OF CARE

A continuum of care must be provided for the care of the aged, disabled & chronically ill.

This continuum is a system of linkages from in-home (or alternate home) care services to long-term care facilities and hospitals or other alternate institutions (e.g. psychiatric facilities) to ensure continuity of care without interruption for those moving within the care system. It involves providing the most appropriate care setting whether that means in the person's home, an alternate residence, or an institution.

5.3.A. HOME AND COMMUNITY CARE SERVICES

5.3.A.1. SUPPORT FOR EXISTING PROGRAMS/SERVICES AND VOLUNTEERISM

Recommendation # 2

That: existing Health and Social Services programs and services be maintained and expanded where the needs exist.

Recommendation # 3

That: in recognition of their valuable contribution, the Government undertake to support and expand the role of volunteers wherever possible.

DISCUSSION

Throughout the course of the project it became clear that existing programs and services are important components (in varying degrees) to providing and maintaining a community structure to provide in home/in community care. The option to include the following components in a particular community care delivery program, should be maintained. These components include:

- homemaker
- handyman service(s)
- errand running
- transportation service(s)
- friendly visiting
- meals on wheels
- equipment loan

As well, in providing these services, project staff note that volunteers are one of the most important resources available. Their efforts enhance the daily lives of many clients by providing nutritious meals, transportation, assistance with household chores and home maintenance, visiting, errand running and many other services. Volunteers are not only major providers of service, but are also, in many cases, the critical link between house-bound clients and their community. Programs that develop to meet community needs should, therefore, promote volunteerism.

An example of tangible support might be:
Where a community volunteer program has been developed under the auspices of the Community Health & Social Services committee, funding could be provided to defray gas expenses for transportation of elders/disabled persons to established programs eg. day care.

5.3.A.2 HOUSING

Recommendation # 4

That: when planning the yearly housing allocation for a particular community consideration be given to the needs of the Aged, Disabled and Chronically Ill for the development of:

- one (1) bedroom houses;
- one (1) bedroom or batchelor suites in the form of row housing or Senior Citizen's Homes;
- "Granny/Grandpa" suites to existing homes.
- provision for extended family in seniors own home

Recommendation # 5

That: existing grants for elderly homeowners be maintained by the N.W.T. Housing Corporation with a view to increasing the present funding allowance.

Recommendation # 6

That: information regarding housing improvement grants for seniors and disabled persons be circulated to all community councils and social service staff.

Recommendation # 7

That: the NWT Housing Corporation (in consultation with the Department of Social Services) develop a "Special Needs Fund" for use in providing accessibility type renovations for clients (e.g.. ramps, grab bars, etc.).

Recommendation # 8

That: the "Special Needs Funds" be available based on the need and whether or not the home is government owned or private.

Recommendation # 9

That: "Accessibility Standards" be developed to ensure that barriers to access by aged and disabled persons are minimized and that these standards be applied to all new public buildings/ public housing units being built or renovated in the future.

Recommendation # 10

That: in small communities the merits of construction of multi-purpose homes be considered.

Recommendation # 11

That: in future, where accommodation for senior citizens is being approved for construction, that attention be paid to the fact that personal care may need to be provided there and thus accessibility and layout is a prime concern.

DISCUSSION:

Many problems: family violence, abuse(s), inadequate sanitation, and the like have been attributed to the short supply of adequate housing. Project Officers frequently found three and four generations, over twenty people, living in the same 3 bedroom house. Probably there was as much friction among people living in close quarters in the past as there is now -- except now people feel trapped in the same community by work and school, and in the same house by a housing shortage -- and by the burden of caring for people who cannot manage by themselves. People cannot easily get away from stressful situations. Because of their commitments, they cannot so easily leave and camp somewhere else to get a break from each other.

Everyone needs adequate housing. Many elders told the officers they prefer to live on their own but near to their families. Elderly couples and singles need one bedroom units in their own community. Suitable accommodation for elders would relieve overcrowding in family homes. If the elders can move across the street, or elsewhere in the community, to smaller homes of their own, young families can have the larger houses to themselves. Old people can have peace, quiet, and company when they want it. All would benefit. Moving across the street or across the community to your own place is also not the same as going out of the community for care. At the same time, Seniors Citizens Lodges do not have to be warehouses where seniors will be forgotten. In the communities, seniors who have family see them frequently, whether they live on their own or in a Seniors Lodge, or in the same house with family. The project findings agree with studies done elsewhere which show that families part with their elders very reluctantly, if at all, and they try to maintain links with them.

In some communities there is a need for smaller units - one (1) bedroom. These could be built free standing or in row housing style (elders usually enjoy being close together). Another possibility would be the addition of a "Granny/Grandpa" suite to existing homes (one could add on a room to an existing home to permit elders to live with family yet have some measure of privacy and remain in charge of their own lives (this may also be ideal for an elder in need of care).

On a number of occasions, project staff were confronted by the problem of the elder who owned their own homes who could not afford to pay to have them repaired/renovated (and did not wish to move out to public accommodation). There is currently a grant arrangement available from the NWT Housing Corporation (the Senior Citizens Home Repair Program) which will provide up to $5000 to make specified repairs. Given the cost of transporting materials to many of the communities, the officers visited (mostly off road) and for the labour rates which are charged to do the work this amount of money is considered in-adequate to do a proper job and the amount should be raised significantly.

Information on these grants should be made available to community councils and Social Services staff as Project Officers found a number were not aware of this option.

From time to time clients have unforeseen changes in health status (e.g.. a stroke or an accident) and as part of their return to the community and to as normal a life style as possible, there may be need for renovations to their home to ensure that it is accessible e.g.. a ramp may need to be installed as a supplement (or replacement) to existing steps or the installation of grab bars beside toilets and tubs for safety and assistance.

Currently there is no specific policy to deal with these sudden needs that arise. This leaves the local housing authority (for rental units) to find money from their existing budget or the need goes unmet. This problem arises every year. It could be alleviated somewhat by having a special contingency fund from which to draw as needs are identified. This money should be available on the basis of need whether the person is in public owned or in privately owned accommodation.

The administration of the fund should be handled by the NWT Housing Corporation (as lead agency for housing) and developed in consultation with the Department of Social Services.

Public housing accounts for the majority of housing available in most small communities.

In some communities, Senior Citizen's housing units have been developed. Other projects are in various stages of proposal, planning, and construction.

Clients usually are self-sufficient. As time passes however, health deterioration can be expected. Because this is a fact of life, planning must occur before a senior citizens home is built, to ensure accessibility and to maximize a person's ability to cope with health decline - or at least to aid care providers in meeting the client's personal care needs e.g. bathing, laundry, meals, recreation and socialization.

In small communities, construction of a free standing personal care home, for example, would not be cost efficient. There are however other needs (e.g. senior's housing, respite care, adult day care, and safe houses for victims of spousal assault, etc.) for which accommodation is being considered. It may be feasible to consider the development of one facility as multipurpose to serve several presenting needs. The feasibility of this option should be further explored.

Over the years a number of house styles have been developed. Some of these styles, particularly those where one must climb stairs to get to the bathroom or bedroom, present major obstacles to the mobility of elders or disabled persons.

Along with housing, consideration must also be given to ensuring access to the rest of the communities public buildings. Almost all existing old buildings and even many new buildings present obstacles.

Reasonable "Accessibility Standards" need to be developed and applied to all new public buildings/public housing units built or renovated in the future.

Recommendation # 12

THAT: The Executive Council of the Government of the Northwest Territories (GNWT) establish policy direction that all public buildings constructed, renovated, leased or funded by the GNWT be required to be architecturally accessible to infirm/disabled clients as a condition for funding.

Recommendation # 13

THAT: The GNWT encourage community authorities (e.g.. Community Councils, Band councils) to discuss accessibility design concerns with building owners as part of the construction or renovation approval process.

DISCUSSION

Architectural inaccessibility is one of the most overt barriers to infirm/disabled persons.

Throughout the NWT, little attention has been devoted to consideration of independent mobility of infirm/disabled persons even in some of the Sr. Citizens homes that have been built. The same of course holds true in many other parts of Canada.

In more recent times, some of the larger communities are demonstrating an awareness of the mobility/accessibility problem faced by infirm/disabled persons, and they have begun to make provisions in public construction projects - e.g. sidewalk curbs, construction of access ramps, door widths, washroom access, etc.

In most communities there are no provisions whatsoever - not even where new construction is underway or has just been completed.

EXAMPLES OF THE CONCERN

A. COMMUNITY OFFICE/GYM BUILDINGS:

The newly completed community office building has a ramp to the door but this does not meet the door sill so one has to step up 6-8" to get over the threshold. There is no internal access (other than stairs) to the gym/community meeting area.

B. NEW SCHOOL:

At the time that the Project Officer was in the community, a new school was in the final stages of construction completion, and was already occupied. On looking at the school design, one was impressed with the exterior ramp arrangements to both levels of the building. The school is completely accessible from the outside, however, it is impossible for a disabled person to navigate the interior stairs in a wheelchair and dangerous at the very least for someone with crutches or a cane. When someone had to get to the facilities downstairs, one

would either have to be carried down by someone or go outside around and down to the first floor ramps to get in - this providing he/she could navigate the rough rocky landscape. This was a particular concern in that a child was soon to be returned from Hospital with crutches and/or wheelchair.

C. PRIVATE COMMUNITY STORES:

Stores in communities not only provide goods and services, but also serve as an important place for socializing. Most stores have a number of steps and small entrance ways. They have not been designed with needs of elderly, infirm, or disabled persons in mind.

5.3.A.4 HOMEMAKER SERVICES

Recommendation # 14

That: a comprehensive Homemaker (Home Health Aide) training program be developed to provide instruction to existing and future workers and provided in each region of the NWT.

Recommendation # 15

That: in conjunction with the training program for workers, that policy and procedure guidelines be provided to supervisors (e.g. job descriptions, recording and reporting, evaluation of services).

DISCUSSION

In meeting with Social Services workers and homemakers throughout the course of the project, problems and frustrations were noted which result from a lack of a practical training program for homemakers.

Ideally, the homemaker should be a Home Health Aide and should act as an assistant to professional Health and Social Services staff (who are responsible for providing home care services). As an assistant, the homemaker should provide and demonstrate the care of home and family, hygiene, nutrition, disease prevention and good health practices. These tasks must be carried out based on an understanding of human needs and using learned knowledge and skills. To provide a standard by which to provide services to clients, a training program for homemakers should be developed. In our research we noted that programs have been developed by several provinces. This program would of course have to be tailored to meet specific NWT needs.

To address concerns of those supervising homemakers, specific administrative policies and procedures should be developed to ensure that quality service is provided.

5.3.A.5 HOME NURSING CARE

Recommendation # 16

MANDATE FOR COMMUNITY NURSES

That: discussions be held with appropriate authorities regarding extending the mandate of Medical Service nurses to include provision of home nursing care of clients.

Recommendation # 17

STAFFING REVIEW TO ENSURE THERE IS MANPOWER TO DO THE JOB

That: an examination of existing community nursing and Social Services staffing be undertaken (for each community).

Recommendation # 18

ROUTINE RELIEF OF NURSES

That: the practice of utilizing nurses in stations for routine relief at other stations be minimized.

Recommendation # 19

REGIONAL FLOAT BACK UP

That: a float pool of registered nurses be developed at Regional Headquarters to provide for routine relief and for assisting stations experiencing peaking workloads.

DISCUSSION:

Provision of home nursing services in the smaller communities (in those without established Co-ordinated Home Care Programs) requires a shift in workload emphasis from that which is currently placed on the nurses.

The person responsible for co-ordination of Home Care locally should be the Nurse in Charge. However, before additional responsibility for providing home care can be required, it is important that there be an understanding of the existing mandates of the Nursing Stations (currently operated in 3 regions by Health and Welfare Canada and in 1 region by G.N.W.T.) and some changes that need to be made.

Currently, federal nurses have two (2) mandates:

1. provide for acute care emergency needs, and
2. provide for public health needs.

In the performance of these duties, nurses feel (and their workloads indicate) that they are swamped with the existing workload.

At the present time there is no mandate for the third essential component of the care that needs to be available in the community -- the "home" aspect (Home Nursing and provision of various supports).

In order for the proposed Community Health Center approach to succeed, nurses must be involved in coordinating these programs as well.

In recommending this approach, there are two other problems that must be addressed in order to ensure that the nursing staff have the time necessary to accomplish the task.

1. Staffing must be provided for responsibilities which can be provided by Community Health Representatives (see discussion and recommendations in Section 5.3.A.11) and duties which could be assigned to clerical staff.

2. There is a continual registered nurse manpower shortage. As a result, station nurses are routinely called upon to provide relief at other nursing stations for unfilled vacancies (vacation), lieu time, sick time and peak caseloads. It was found for example that:

   2 RN stations had effectively 1.5 RNs available.
   3 RN stations had effectively 2 RNs available.
   4 RN stations had effectively 3 RNs available.

These factors contribute to frustration and understandable resentment at assuming changes in workload and in part for the high turnover experienced.

In the writer's opinion, these must be addressed when implementing the approach proposed.

5.3.A.6 CO-ORDINATED HOMECARE PROGRAMS

Recommendation # 20

THAT: existing programs be maintained, monitored for workload and changes, and adjusted accordingly to ensure that needs of all clients are being met adequately.

Recommendation # 21

THAT: Co-ordinated Home Care programs be established in the following communities:

Baker Lake
Cambridge Bay
Coppermine
Fort Simpson
Iqaluit (Frobisher Bay)
Rankin Inlet

Note: These are alphabetically listed not prioritized.

Recommendation # 22

THAT: discussions be held regarding development and implementation of a model for Home Care program delivery in small communities.

Discussion

Co-ordinated Home Care programs are currently offered in the larger NWT communities: Fort Smith, Hay River, Inuvik, and Yellowknife. (Specific information on these is found in appendix 1).

Anticipated effects of the Programs

1. On Clients, and Health and Social Services

Development of Home Care programs in the client's home community is essential:

1.1 to promote individual and family independence by providing the minimum levels of service(s) needed and to delay or prevent functional deterioration;

1.2 to help families cope with the responsibility of caring for their family members;

1.3 to provide services to bridge the gap between the person's needs and the services the individual and family can perform themselves;

1.4 to serve as an integral part of the Health and Social Services system of care by delaying the need for an individual to be placed in an institutional setting, by helping care for a person until placement is possible, by allowing for earlier discharge from hospitals, and by reducing the number of Hospital admissions and re-admissions.

2. On Costs

Home care provides a much lower cost alternative to institutional care. We note in figures quoted in studies done by one province (Saskatchewan) that "every new special care home bed will cost about $65,000 to build and another $30,000 /year to operate. In contrast, the cost of supporting a person with substantial needs at home seldom exceeds $12,000. annually".

A large part of the difference in cost is due to the support and care contributed by family, friends, and neighbors while a person lives at home.

These alternatives (and others in this report) when put into effect, will not result in a net gain for Health and Social Services budgets. In fact, in the short term, these alternatives will increase the cost of caring for clients. However, the extent that home programs can, in the long term, moderate the need for institutional acute and long term care beds, costs will undoubtedly be reduced, and the welfare of the individual will be maximized.

Home Care programs should be established in a number of communities. In some cases, the homemaker services component of the program exists to some degree. What is now needed is the professional nursing care component. Elsewhere in this report it has been recommended that the Nurse in Charge (NIC) of the community nursing station should be responsible for providing the professional component, with the proviso that certain back up is available to free time to accomplish the task at hand. Discussions should be held between the parties concerned to develop and implement new programs using a model appropriate to small communities.

5.3.A.7 ALCOHOL & DRUG PROGRAMS

Recommendation # 23

That: N.W.T. Alcohol & Drug Services (Social Services) and N.N.A.D.A.P. (National Native Alcohol & Drug Abuse Program - funded by Health & Welfare Canada) continue funding and evaluating existing alcohol and drug programs, and encourage the development of programs in communities where no programs currently exist.

Discussion

Clients being considered by the Assessment Project are affected in varying degrees by alcohol and drug abuse. Sometimes this effect is self-inflicted health and social deterioration as a result of their own abuse. Sometimes the affects are the result of family members abuse.

In many communities, alcohol and drug education awareness programs are functional. In others, the needs exist but there is little or no initiative shown to acknowledge and deal with the problems. The television coverage given Alkali Lake and the regeneration that is taking place there as a result of their acknowledgement of the problem and developing a plan to deal with it themselves, has encouraged a number of communities to get serious about this matter.

5.3.A.8. MENTAL HEALTH CARE

Recommendation # 24

That priority be given to the establishment of a comprehensive Mental Health Care Assessment Project to review:

1. **appropriateness and effectiveness of existing programs and services;**

2. **circumstances and conditions which create mental health problems in the north;**

3. **options which may exist for effective intervention;**

for the purpose of providing a comprehensive planning and approach to provision of the Mental Health Care Delivery System.

DISCUSSION

Mental health care concerns are included in this report as a result of views and concerns expressed by people from the various communities.

Present programs are perceived as not meeting needs and, therefore, there is need for review.

In the 1969 report and recommendations of the "Mental Health Survey Team" (Health and Welfare) the following statements are made (pg. 38-43):

> "In offering recommendations for the creation of mental health facilities, the general principle of treating a mentally ill person as close to his own community as possible is maintained. It has been accepted for a considerable period of time that a major principle of treatment of the mentally ill is to maintain close contact with the environment to which they will be rehabilitated. This purpose cannot be achieved if large mental hospitals are built far from the patient's environment or if people are transported long distances for treatment, and to an environment with unfamiliar personnel and very often barriers to communication because of language difficulties. Accepting this general principle, it is our opinion that the first line of treatment is the consultant, in the community, working at an outpatient level. This would include the Public Health nurse, the Welfare Worker, the indigenous worker and others who contact the human being at the point in the community where his problems are being created.
>
> It has been successfully demonstrated in the southern communities that the majority of psychiatric casualties can be successfully treated in the general hospital setting.

> We would recommend that as far as possible, general hospitals such as Whitehorse, Yellowknife, Inuvik and Frobisher Bay should have appropriate beds set aside for psychiatric care. Arrangements might also be made for similar facilities at the hospital in Churchill, Manitoba. If consultation and permanent psychiatric personnel can be achieved, there will be little difficulty in treating the majority of psychiatric disorders in these five centers. It would also necessitate equipping these units appropriately with equipment for physical treatment, and with appropriate pharmacological stocks. Training of personnel will be most important..."

The "Mackenzie River Area Health Services Study" by Gordon A. Friesen (Can) Ltd. in 1975 identified the problem as follows:

> "The provision of Psychiatric Services in the NWT is one of the serious gaps in the health care program." (p. 117)

The Friesen report supports the recommendations of the "Mental Health Survey Team" stating:

> "Provided that adequate medical care, adequate acute care facilities and adequate consultation were available the majority of chronically mentally ill and grossly defective individuals, who are for the most part passive in behavior, the multi-handicapped patients, and also the majority of sclerotic geriatric patients could be cared for in selected communities in the Northwest Territories." (p. 119)

In the 1979 report entitled "The Yellowknife Mental Health Study" by Jan Hill, R.N. (Alberta Mental Health Services) she summarizes a number of problems from that particular community. These problems, however, are not just Yellowknife problems as the Project Officer's found in conducting the Assessment Project.

These include:

- fragmentation of services/programs;
- unsatisfactory communications, assessment and treatment;
- inadequate physical facilities to effectively treat mentally ill patients;
- a lack of counselling services;
- a lack of therapy to assist native persons to adjust to a changing lifestyle;
- a lack of an adequate assessment and therapy for those incarcerated at the correction centers;
- a lack of mandate and action plan to deliver programs and services.

Since that time, some development of the Mental Health Care Delivery has been initiated by the establishment of a Psychiatric Services Program based at Stanton Yellowknife Hospital. However, this program, due to staffing difficulties and high staffing turnover, has not been able to respond adequately to the needs. The

program was designed to respond to meet immediate and critical needs with the hope that an overall plan designed to meet mental health needs could be developed. Many individuals, groups and communities have expressed increasing concern regarding the services, family violence, child abuse, alcohol and drug related problems and other mental health issues.

Responses by Government (Territorial and Federal) have been with a number of interventions designed to meet the immediate most critical need. However, there is no overall plan for mental health programs delivery to which one can turn.

There is a need for complete identification of the existing problems in providing a Mental Health Care Delivery and development of a comprehensive approach. Elements of the review should include:

1. a review and evaluation of existing mental health programs and services with a particular view to the aspect of co-ordination;
2. a review of community-based mental health program options;
3. an assessment of manpower and training requirements for an integrated mental health service;
4. community and regional consultation on problems and needs;
5. identification of priority program and service delivery needs.

Concurrently, there must be continued efforts to provide emergency intervention and support for persons suffering from mental health problems.

Recommendation # 25

That: aggressive recruitment efforts be instituted to staff existing rehabilitation vacancies.

Recommendation # 26

That: the present classification standards for rehabilitation staff be reviewed to ensure that well qualified personnel can be attracted in the current time of manpower shortage across the country.

Recommendation # 27

That: exiting specialized rehabilitation services (Audiology, Occupational Therapy, Physiotherapy, and Speech Therapy) be expanded to under serviced regions.

Recommendation # 28

That: rehabilitation services be expanded to include rehabilitation programs for home care and long term care.

Recommendation # 29

That: consideration be given to establishing Level 5 (Rehabilitation) Beds in the N.W.T.

Discussion

The Department of Health provides N.W.T. residents with rehabilitation services offered through the following institutions:
. Baffin Regional Hospital, Frobisher Bay
. Fort Smith Health Center, Fort Smith
. H.H. Williams Memorial Hospital, Hay River
. Stanton Yellowknife Hospital, Yellowknife
. Inuvik Long Term Care Facility, Inuvik

Table 1 and Table 2 show the existing funded rehabilitation positions and the existing staffed positions. 5.2 FTE vacancies may not seem like a lot however, when one considers that this represents over 40% of the rehabilitation work force, and the complete absence of service in two regions, and decreased service offered in 2 out of 3 of the communities in the third region, there is sufficient reason for concern.

The lack of qualified rehabilitation personnel to fill available vacancies in Canadian Health Care facilities is documented at both provincial and Federal levels. There are proposals being developed for national initiatives to, in the long term, relieve the problem. However, in the short term, the N.W.T. is going to find recruitment most difficult. In addition, the present classification for occupational therapists, and physiotherapists, does

not provide a salary range that will attract staff in a time of a manpower shortage. Other strategies for recruitment could include an active interning program, aggressive advertising and recruitment activities perhaps similar to the Physician Recruitment Program.

TABLE 1 Rehabilitation staffing by region, by profession, by existing approved positions as of November 1986.

Region	Audiology	Occ. Ther.	Physio	Speech Path.
Baffin Region				
Frobisher Bay	0	0	1.0	0
Ft. Smith Region				
Ft. Smith	0	0	.75	0
Hay River	0	0	1.0	0
Yellowknife	1.0	2.0	3.2	1.0
Inuvik Region				
Inuvik	0	1.0	1.0 *	0
Keewatin Region	0	0	0	0
Kitikmeot Region	0	0	0	0
Totals	1.0	3.0	6.95	1.0

Total approved positions in the N.W.T. = 11.95 FTE
(* Federally funded)

Table 2

Rehabilitation staffing - Existing staffed positions as of November 1986

Region	Audiology	Occ. Ther.	Physio	Speech Path.
Baffin Region				
Frobisher Bay	0	0	0	0
Ft. Smith Region				
Ft. Smith	0	0	.75	0
Hay River	0	0	0	0
Yellowknife	1.0	2.0	2.0	1.0
Inuvik Region				
Inuvik	0	0	0 *	0
Keewatin Region	0	0	0	0
Kitikmeot Region	0	0	0	0
Totals	1.0	2.0	2.75	1.0

* Federally funded position

Total staffed rehabilitation positions = 6.75

CURRENT VACANCIES (Approved positions less staffed) = 5.2

It is of note that only one region, Fort Smith Region, has speech and audiology positions. Service is provided on a consultation basis from Yellowknife to the other communities of the Fort Smith Region as well as Kitikmeot Region. Speech and Audiology services however, are a necessity in all regions.

Occupational Therapy is provided on a consultation basis from Yellowknife to Hay River and Ft. Smith. As there are long term care facilities (a portion of the Hospital) in both these communities, on site occupational therapy staffing should be considered to provide the required level of service. Only Inuvik Long Term Care Facility is funded to provide Occupational Therapy, and that position is vacant. St. Theresa's Home (Chesterfield Inlet) has 12 Level 2 and Level 3 clients and has no regular physiotherapy or occupational therapy service available.

In Long Term Care, Occupational and Physiotherapy work as part of the team of physicians and nurses to provide co-ordinated assessment and treatment for each client/resident. The aim of rehabilitation is to maximize the potential of the client in some cases allowing for return placement at home, and in other cases to prevent unnecessary deterioration of movement or function. Rehabilitation services are required to meet the needs of present Level 3 and Level 4 clients.

In home provided care, the physiotherapist/occupational therapist plans, organizes and directs programs of treatment for clients and their families, or those caring for them to ensure that the client is able to function effectively in the home environment as well as remain in the community rather than in an institution. The therapists are also involved in training and educating the client and the family relating to the presenting problems. At this time, rehabilitation staff are seldom able to provide service to home care clients because of the demands of the hospital based programs.

Homes in communities vary over a range from spotlessly clean to very untidy; from "matchbox" houses to energy efficient models; from traditional living styles (such as sitting on the floor for eating and most activities and sleeping the whole family together on a "sleeping platform") to usual Euro-Canadian manner and customs. It is very important that therapy involving A.D.L. (Activities of Daily Living) be prescribed individually to suit the situation. Given the hazards and difficulty of interpreting language and custom from one culture to another, there would seem to be no acceptable substitute for regular home visits by the occupational therapist and physiotherapist.

At the present time, persons requiring level 5 care (Active Rehabilitation) are sent out to referral centers in the south. When they return home, in many cases, there is little follow-up because there are no qualified personnel locally. Consequentially, much of the benefit of the intensive rehabilitation program can be lost. If services were offered for level 5 clients here in the N.W.T., there would be less upheaval for families,

and more continuity of service. However, simply designating level 5 beds at a particular hospital would not solve the problem unless the programs were funded to provide an appropriate staffing level for intensive rehabilitation as is found in southern facilities. In those (southern) locations, each client receives a full day of therapy from physiotherapy, occupational therapy and often speech therapy. Of necessity, the case load is very low per therapist because of the concentrated time that must be spent with each client. When one considers the total cost and dislocation involved in sending level 5 clients south for this care as compared to developing and operating level 5 programs in the N.W.T. it is believed that this would be cost-beneficial.

S.3.A.10. EARLY INTERVENTION PROJECTS

Recommendation # 30

That: the mandate for "early intervention programs" be established and funded, and that services be available to all regions.

DISCUSSION

During 1985/86 a community based early intervention pilot program for preschool children with developmental delay was offered to families in Pond Inlet. It provided in-home parent training and assistance for the parents of infants and preschoolers who were demonstrating special needs in their development. It was reported that there were significant developmental gains in the children and good parental support for the program.

In the south, early intervention programs are available. It is also of note that each province has struggled with the problem of whose mandate it is to provide this service. No one way emerges as a guide.

At the present time in the NWT no department feels that early intervention is their mandated responsibility.

The needs of children with developmental delay will continue to be unmet until such time as some department is assigned this responsibility and provided with the necessary additional resources to develop and implement the program.

5.3.A.11. COMMUNITY HEALTH REPRESENTATIVES (CHR)

Recommendation # 31

That: priority be given to filling of current vacant CHR positions.

Recommendation # 32

That: CHR positions be established in every community.

Recommendation # 33

That: a training program for CHRs be developed and implemented in the NWT.

DISCUSSION

The CHR National Committee's Task Force Report in developing a basic model of what the CHR does, states as follows:

> "The basic role of the CHR is seen as a 'Community Health Developer'. What is meant by this is that the CHR works with all members of the community, to encourage people/groups "at risk", to develop their capacities and to take charge of their own health. These key points must be done at the Indian (or Inuit) peoples' time and at their own level.
>
> In order to achieve the above points, the CHR performs five basic functions:

(i)	ADVISING	To give recommendations for change as it relates to lifestyle and what future action could be taken.
(ii)	COUNSELLING	To work with individuals and families in making choices that affect their lives.
(iii)	EDUCATING	To provide community members with the necessary knowledge and skills in order that health choices can be made.
(iv)	PUBLIC RELATIONS	To promote the concept of healthy lifestyles with community members as well as to promote the role of the CHR to other agencies.
(v)	REFERRALS	To make linkages with other appropriate agencies to ensure that the health needs of the community are met.

These functions are taking place in the home, school and community."

In our review we noted that some communities have trained and experienced CHRs. Nurses informed us that these workers provided a valuable assistance in delivery and support of the local preventative health program.

At the present time there are 15 CHR positions in NWT communities. It was noted that a number of these were vacant at the time of survey.

Recommendation # 34

MULTIDISCIPLINARY CLIENT ASSESSMENT UNIT PROGRAMS

That: where possible regional multidisciplinary assessment programs be developed.

Recommendation # 35

ADULT DAY CARE

That: priority be given to the development and funding of adult day care programs operated as a component of personal care/ long-term care programing.

Recommendation # 36

RESPITE CARE

That: community and facility based respite care programs be developed and funded.

Recommendation # 37

FOSTER FAMILY CARE

That: where feasible, foster family care be expanded to accommodate the needs of aged and chronically ill persons.

DISCUSSION

Intermediary care is a term used to refer to the resources which are developed and situated between a client's home setting and an institution. Resources need to be developed to assess clients and to maintain a person in an environment integrated as far as possible within his/her community.

These should include:

1. Multidisciplinary client assessment unit program,
2. adult day care programs,
3. respite care programs,
4. foster family arrangements,

<u>MULTIDISCIPLINARY CLIENT ASSESSMENT</u>

Many Aged, Disabled and Chronically ill clients may present a complex diagnostic and treatment situation in which organic disease may be accompanied by functional impairment, social problems and, in some cases, emotional disorder(s). In order to maximize the benefits of Home Care and other programs, a Multidisciplinary Assessment and Action plan is essential.

Other jurisdictions, notably the United Kingdom, have pioneered methods to improve health care for the frail elderly. There, they established geriatric assessment units which, although hospital-based, are primarily oriented toward maintaining the client in the community. This objective is attained through community outreach programs, which reduce preventable or inappropriate institutionalization, and improvements in hospital programming which increase the number of clients who can be returned to the community following necessary treatment. A multidisciplinary assessment/case management consultation approach is used. In the United Kingdom, the introduction of these units has resulted in demonstrable decreases in preventable institutional admissions, improvements in the quality of care, reductions in complications after illness or accidents, shorter lengths of stay in hospital, and fewer blocked hospital beds.

In Canada at the present time, a number of similar projects have developed - geriatric and psycho-geriatric assessment units and/or specialized programs such as day hospital outreach programs. They are usually located in major regional centers. It is likely only possible to provide these Assessments in the major regional hospitals here in the N.W.T.

2. ADULT DAY CARE PROGRAMS

Adult Day care is a social program which allows individuals to be cared for during selected hours on specified days throughout the week. This provides the client an opportunity to maintain and maximize his potential through structured activities, socialization with peers, a meal out, and a change of environment. It allows the primary care giver to be relieved for short periods.

Other components of the program may include: medication supervision; physical and occupational therapy; personal hygiene care; and community outings via safe and reliable transportation.

Adult day care programs are seen as an important outreach component for facilities currently providing personal care/ long term care.

3.RESPITE CARE

Temporary sheltering (Respite care) offers a resource to families and individuals who are looking after Aged, Disabled, and Chronically Ill persons at home. This resource seeks to give the caregiver a short rest period. Such temporary shelters could be located in foster homes, personal care homes, long term care facilities depending on the needs of the particular client. These programs should be encouraged and further developed. It is recognized that Hospitals do provide some respite care services on an "as available basis". At the present time, Inuvik Long Term Care Facility is the only N.W.T. facility with approved designated beds for respite care.

4. FOSTER FAMILY

For certain clients, the foster family may represent a resource which would enable them to live in an environment which is similar to their home setting and receive adequate care. Foster homes may be able to prevent or at least retard placement in an institution or even assist the person in returning to his/her own home. This resource is more commonly used by Social Services for placement of children in care, children (and sometimes adults) with mental or other disabilities. It has been tried successfully in several provincial jurisdictions, and merits further consideration and development in the N.W.T.

5.3.A.13 ELDER WELL-BEING

Recommendation # 38

That: The phenomenon of elder abuse(s) in the N.W.T. be explored in depth.

DISCUSSION

The suggestion that elders are abused troubles all deliverers of social and health services. With the family violence that often accompanies drinking, it seems likely that some elders are attacked or threatened. Elder abuse is hidden and few elders are likely to complain. The Project Officers, like other government officials cannot estimate how widespread the problem is. However, providing elders with physically separate shelters would reduce the occasion for violence.

Social service and Nursing personnel in some communities suspect some families take their elder's old age pension cheques. If the families use the money against the will of the elder, this should be prevented by having the cheque cashed by a more trustworthy person. However, many elders told the Project Officers that they were glad to have a pension; it means they can contribute something to the household now that they can no longer hunt, fish, sew skins, or care for the children.

In an article in the spring 1985 issue of "Community Options", Betty Havens, Manitoba Provincial Gerontologist writes:

> " Abuse of the elderly presents special problems for both government and a concerned community: it still has to be identified and defined, at the same time as it is being confronted. The reason is simple. Very little is known about the nature and extent of abuse of the elderly. More than wife and child abuse, it is difficult to identify, because the victims are especially unwilling to reveal that they have been abused. And there can be a fine line between neglect and ignorance in caring for the elderly and actual abuse.
>
> Abuse can take several forms. There is physical abuse, which can range from withholding food to physical assault and homicide. There is emotional-psychological (including verbal) abuse: being treated as a child, threats and humiliation, name-calling. Financial abuse is perhaps the most common form of mistreatment of the elderly. This includes misappropriation of funds, disposal of assets without consent or failure to manage income or assets properly.
>
> Neglect of the elderly is a closely related problem. Some caregivers fail to give adequate or proper care to elderly friends and relatives, or through ignorance, allow a relative's health to be mismanaged.

> Among the elderly, persons 75 or older are the most vulnerable to abuse. Some studies suggest that two-thirds of the victims are women and that most live with friends or relatives. Social isolation is not a factor.
>
> Because of the humiliation of being abused and the difficulty of admitting that someone close to them is an abuser, few victims come forward to seek help. Thus estimating the incidence of abuse is almost impossible."

Various provincial jurisdictions have done studies and published their findings.

To date the issue presented has not been as public an issue as spousal assault and child abuse - it is still an "underground" problem.

Project officers were made aware of situations similar to the above and we therefore believe this matter requires further investigation.

5.3.B LONG TERM CARE

5.3.B.1 INSTITUTIONAL CARE

Recommendation # 39

That: the Departments of Health and Social Services construct and operate regional and community facilities where indicated by the survey of needs. [Note: This could be accomplished directly by government operating the facility or by contract arrangement with a non-profit society eg. Yellowknife Personal Care Home]

DISCUSSION

Along with the services available as "Home or Intermediary Services" there is a need to provide long-term institutional care for persons whose needs cannot be met in their home community and who require nursing care and supervision (level 3 and 4.)

At the present time there are 56 Level 3 and 4 beds in the NWT for provision of this care. (See appendix 7.8 for distribution)

During the consultation process, the majority of concerns regarding long-term care focused on the perception that many persons who were assessed at levels 2 and 3 could be maintained in their own homes if appropriate care services were available. As well, there is a lack of suitable alternatives in all the regions. As a result, clients have had to be removed from their home region and institutionalized elsewhere - either in the NWT if suitable space can be found or in facilities in southern Canada.

Table #24 (Section 4.4) indicates that there are currently 46 level 3 and 10 level 4 clients being maintained thru various measures. As well, there are 247 level 2 clients who can be expected to progress to level 3/level 4 within the next 3 to 10 years (admittedly this is most difficult to predict with accuracy). There are also a number of persons listed in "future" who may progress to the point where they require some care assistance.

It is not feasibile to consider constructing and staffing Long Term Care Facilities in every community. However, based on regional needs, geographic travel considerations, and placing importance on maintaining a person as close to their home as possible, priority should be given to establishing at least one facility per region. At present a number of persons are completely displaced from their home region (e.g. a Frobisher Bay client placed in Inuvik; a Spence Bay client placed in Ft Simpson). As well, there is the matter of inappropriate placement of clients in acute care hospital beds for respite or awaiting placement elsewhere.

It is recommended that plans be developed for the construction and staffing of Senior Citizen's Care Facilities as follows:

BAFFIN REGION:

The need for and requests for support in caring for clients in the Baffin are increasing. The Assessment Project has identified a number of clients who currently need Personal Care Level (level 2) and Long-term Institutional Care (levels 3 and 4). (See Tables for Baffin region in section 4.4) Some of these clients are placed in Inuvik, Hay River and in the South.

Over the past number of years, aged and disabled clients have come to Iqaluit (Frobisher Bay). Displaced from their home communities, they now call Iqaluit (Frobisher Bay) home.

Some of these persons can best be supported by establishing a Homecare program. Consideration also needs to be given to establishment of a Senior Citizen's/Personal Care home and to the construction of a Long-term Care facility in conjunction with the Hospital to serve the Baffin Region.

Another need identified is for a group home for handicapped adults. At the present time there are about 15 individuals in Baffin communities and southern facilities.

FORT SMITH REGION

The needs exist in several communities for additional senior citizen's self-care, personal care units and long term care.

Fort Simpson	For completion in 1988.
Fort Smith	In planning stages.
Hay River	Currently under discussion.
Yellowkinfe	The completion and opening of the new 30 bed P.C.(Level 2) Home and new SYH Centre (Level 4) will assist in meeting unmet needs here, however, there will need to be provisions made for Level 3 clients.

INUVIK REGION

Self-care and personal care units are needed in Inuvik to meet the needs of clients there.

KEEWATIN REGION

Group home facilities for handicapped adults and children and personal care needs are under discussion. The figures justify the existance of the needs. A decision then needs to be taken as to sizing and placement.

KITIKMEOT REGION

This region has a number of individuals placed in southern institutions who could likely be placed in a regional facility for children and/or adults if one were available. Consideration should be given to the sizing and location of same.

SHOULD GOVERNMENT CONSTRUCT AND OPERATE FACILITIES DIRECTLY?

The questions of who should be responsible for constructing and operating these facilities should be carefully considered. Where possible government should consider making contractual arrangements with Non-profit societies similar to that which has been arranged for the construction and operation of the Yellowknife Personal Care Home. In this manner, government can legitimately avail itself of long term low interest financing from Canada Mortgage and Housing Corporation.

5.3.B.2 VISITATION TRAVEL BENEFITS FOR PERSONS IN INSTITUTIONAL CARE AND FAMILY MEMBERS.

Recommendation # 40

THAT: A visitation travel benefits policy be developed and funded for persons in institutional care and their families where clients are institutionalized outside their home community.

DISCUSSION

An important need for clients and their families is maintaining the social links that exist when a person is "taken away" to an institution.

Distance and cost of travel are major obstacles. Few, if any, clients and/or their families have the money to travel regularly to visit together.

In order to ensure that there is an element of compassion to the care system, we must ensure that family members can be united from time to time.

Not only should we encourage families to visit, but if possible to arrange the client should be permitted some short respite from facility living to go back to his/her own community.

5.3.B.3 REPATRIATION OF CLIENTS

Recommendation # 41

THAT: an in depth review/assessment of N.W.T. residents currently placed in southern facilities be conducted, and that a comprehensive action plan be developed regarding possible repatriation.

DISCUSSION

One of the objectives of the Assessment project was to have collected/updated information on northerners who are aged, disabled, or chronically ill, and who are currently in the care of institutions in southern Canada.

During the time available to project officers there was not time to contact each institution or placement situation to obtain current and detailed assessment information on each client. However, a master client list has been compiled involving some 120 clients placed in various care settings in southern Canada.

It is of note that several agencies have financial responsibility for these clients.

The current trend is towards downsizing in many southern facilities. This has resulted in notification that N.W.T. clients will have to be placed elsewhere within a certain timeframe. Alternate placement is the responsibility of the funding agency.

Within the N.W.T. there are very limited placement resources to provide care for dependent adults, psychiatric patients, psychogeriatric patients, and those who are mentally retarded.

Repatriation considerations include:

1. The degree of care required by the individual and the resources available in the home community or regional center.

2. Consultation with the family and the home community. (Because of the nature of the client's problems - would the move back be accepted by the client, family and friends, others in the community, or would it be more traumatic.)

Given that the downsizing trend will continue, and that N.W.T. has few placement resources, a comprehensive action plan needs to be developed to meet this need.

5.3.C.1 THE CONTINUUM OF CARE FOR ORGANIZATION AND MANAGEMENT

Recommendation # 42

ORGANIZING THE CONTINUUM OF CARE

That: the proposed overall coordinated approach to the Continuum of Care be further developed and adopted by the Departments of Health and Social Services in cooperation with other agencies.

Recommendation # 43

LEGISLATIVE MANDATE

That: a legislative mandate be developed to ensure adequate funding for the Continuum of Care has a high priority.

Recommendation # 44

ESTABLISHMENT OF ONE SYSTEM

That: a system be developed and implemented to co-ordinate the provision of all non-institutional and institutional continuing care services including Home Care Programs, Senior Citizen Housing, Personal Care Homes, Long Term Care Facilities and clients in hospitals.

Recommendation # 45

ESTABLISHMENT OF DIVISION OF COMMUNITY AND CONTINUING CARE

That: a division of Community and Continuing Care be established as a division of the Department of Health to oversee the overall planning and development to ensure the Continuum of Care.

Recommendation # 46

DIVISIONS RESPONSIBILITY

That: the system be responsible for accountability; assessment and placement; travelling rehabilitation services; and consulting professionals.

Recommendation # 47

ESTABLISHMENT OF REGIONAL OFFICES

That: Regional offices of the division of Community and Continuing Care be established to be responsible for management and co-ordination at the regional and community level. [Note: Where Regional Health Boards exist, they should be mandated with the responsibility for recommendation # 47 and 48.]

Recommendation # 48

ENSURING REGIONAL INPUT

That: Regional Community and Continuing Care Advisory Committees be established to ensure Interagency co-operation and co-ordination and that Regional concerns are addressed.

Recommendation # 49

PROVISION OF COMMUNITY ORGANIZATION AND LEADERSHIP

That: community leaders provide leadership and direction by giving priority to establishing Community Health and Social Services planning committees to:

1. **provide local input and decision making in the co-ordination of existing Health and Social Services Programs,**
2. **consider unmet needs, and**
3. **provide for future planning.**

Recommendation # 50

THE APPROACH TO COMMUNITY SERVICES

That: the philosophy of joint Health and Social Services Centres be adopted to formally link and provide community programs and services.

Recommendation # 51

PHYSICAL HOUSING OF PROGRAM STAFF

That: the feasibility of uniting Community Health and Social Services staff, under one roof, be examined.

DISCUSSION

CONSIDERATIONS:
In the review of community after community the Project Officers noted the wide disparity in the range of programs/service available.

The present system of care, includes:

1. co-ordinated home care programs,
2. senior citizens homes/lodges
3. personal care facilities,
4. long term care facilities (a division of a hospital), and
5. hospitals.

In many cases, planning and delivery of services appears to have been done in isolation often resulting either in gaps or in overlapping of available services.

Funds are first allocated to mandated programs and only after those needs are satisfied are allocations made for provision of these programs and services. Community based programs and services for Aged, Disabled & Chronically Ill fall into this latter category.

There is a lack of available information for planning for existing and projected needs (hence the main reason for this review and report);

There is a lack of initiative by many communities in reviewing and considering their own local needs and in presenting these to government.

Project officers noted that the various staff "players" are working hard to develop and provide programs/services, however, a comprehensive delivery system is difficult to achieve because of the lack of an overall co-ordinated approach.

Approaches for change

Having raised the necessity for development of an overall approach for change, on what rationale should this be based?

Essential elements of the Continuum of Care include:

1. Planning
2. Direction
3. Co-ordination
4. Control
5. Accessibility and Quality of Services

Central to our approach must be the consideration of the local communities culture, traditions and needs.

In his proposal entitled "An Indigenous Approach to Care for the Aged," E. W. Drake, former Area Supervisor, Yellowknife Area office, referred to the central concern the Project Officers feel about displacing someone from his/her home: "This means that the Aged must leave their homes for an area which holds no meaning for them. Larger Centers are often traumatic after the small settlement where everyone was able to be on a first name basis. Identities were totally lost. Language variations leave them helpless in communications. The lands where they hunted and fished in their youth are removed from them."

In planning the Continuum of Care, this concern can best be addressed by providing more adequate community based services.

No one plan of action emerges as "the sole way" to solve every community's needs. A "cafeteria" approach to providing services is necessary. Communities need "at home" care services. (Eg. Home Nursing, Homemaker services etc.)

Some communities need housing for Sr. Citizens/Disabled Persons/Chronically Ill geared to their particular needs. To these could be added a personal care component when necessary. A further factor that may influence the type of facility that is constructed is the need for alternate housing (Eg. for spousal assault and other victims.) Therefore what may best suit the community's purposes may be a flexible multi purpose housing unit.

The Proposed Organizational Framework

The identification of shortcomings in existing programs and services should not be construed as suggesting that these are unsound or require total transformation. Nothing could be further from the truth. However, there is need for government to further develop a comprehensive co-ordinated and community based approach to services to the Aged, Disabled and Chronically ill.

1. <u>At the community level</u> the focus should be on organizing to provide care and services .

The Community Health Center approach to local care pursues "Health Promotion" as the basic objective. In it's broadest and most general meaning, "Health" in this context covers the concepts of physical, mental and social well-being.

With this objective in mind, people of the community could organize a community health and social services council to mold the Community Delivery system to fit the population being served bearing in mind socio-economic developments; local population; and priorities defined by government.

The membership for the proposed Community Health & Social Services Councils should include:
- members appointed by the local community council
- the nurse-in-charge of the nursing station
- the Community Social Services worker
- Alcohol and Drug program coordinator
- Community physician (if available locally)

optional members could include:
- a representative from the local Housing Association
- a representative from the Department of Education responsible for children with special needs.

(In general, it is recommended that the council composition not exceed 10 persons) The functions of the Community Health and Social Services Council would include:
- define the purpose, scope and functions to be carried out in the particular community.
- data collection and analysis (Eg. identifying gaps and predictions of future requirements.)
- development of a long range plan.
- development of an immediate (short term) plan.
- development of a functional program plan (where construction is being contemplated.)
- review and updating of data, plans and programs at periodic

intervals.

Ideally, Health and Social Services personnel existing in the community should be joined to work as a team preferably under the same physical roof. In most communities these services are delivered from physically separate buildings. As time proceeds and renovations and replacements are necessary, consideration of this, we believe, is warranted.

2. <u>At the Regional Level</u> the development of a comprehensive coordinated regional approach is most important. A regional office of Community and Continuing Care should be established and operated under direction of the Community and Continuing Care Division; the "Regional Coordinator for Continuing Care." would be responsible for:

   - co-ordination and direction of the Regional program by working under direction of a Regional Coordinating Council.
   - assessment and placement of clients requiring care at the local community level, the regional level and elsewhere as needed.
   - monitoring and controlling regional funding for the program.
   - coordination of training and in-service for community staff (Eg. homemakers.)
   - working with communities in establishing and operation of the local Health and Social Service Coordinating Committee, and in assessing their needs for programs and services.
   - consultation with the Regional Community and Continuing Care Coordinating Council on progress and concerns.

   To ensure inter-agency co-operation and co-ordination and that the program is meeting needs, a Regional Community and Continuing Care Advisory Committee should be established.

   The proposed membership should include the senior regional representatives of the;
   Department of Health,
   Department of Social Services,
   Health and Welfare Canada, and
   Department of Education (adult and special needs education).

   Other agencies involved in providing aspects of "care" to clients include:

   Department of Public Works (repairs and upgrading of housing)
   NWT Housing Corporation Regional Office

   These could perhaps be alternate members of the council called in on discussions as needed.

3. <u>At the Territorial Level</u> there is need for the establishment of a "Community and Continuing Care Division" which would be

the program coordinating center for the NWT. This office should be a division of the Department of Health, who is/will be (as a result of devolution) responsible for community health care. It should be jointly funded by the Departments of Health and Social Services and would be responsible for community program funding, and the planning and development of all continuing care including home nursing care, homemaker and related services, housing for seniors and personal care and long term care facilities. As well, the Division would establish and maintain linkages with institutional programs, (Eg. to maintain assessment, placement and discharge planning.)

The Division should include:

1. a Program Director with knowledge and ability in long term care planning, organization and management;

2. financial management staff;

3. a social worker with supervision and management ability and experience in admission and discharge planning;

4. consultants in nursing and rehabilitation, mental health, special education and special programs (Eg. activity programs);

5. provision for other itinerant consultants such as pharmacists, dieticians; gerontology and psychogeriatrics;

6. adequate administrative and clerical support.

Note: It will also be imperative that the Division have a close link with the department(s) mandated to provide early intervention programs for children with special needs.

One of the major problems facing the human care field in every jurisdiction today is the fragmentation of programs and services and the dilution of our valuable resources - manpower and finance.

Those involved in the delivery of programs and services to clients referred to in this report include:
G.N.W.T. - Health
G.N.W.T. - Social Services
Health & Welfare Canada
G.N.W.T. - Education (Pond Inlet early intervention project)
N.W.T. Housing Corporation (Housing)

The concerns we addressed regarding the Continuum of Care deals with the degree to which programs and services are planned and co-ordinated. To provide a continuum of care for the elderly and for the disabled, all government departments providing continuing care should work through a single delivery agency which would be responsible for user assessment, delivery and auditing of the services provided.

5.3.C.2 MANAGEMENT AND CLIENT INFORMATION SYSTEM

Recommendation # 52

That: a methodology be developed to store, maintain, manipulate and constantly update the information gathered by the Assessment Project for planning, development and delivery of effective programs and services.

Recommendation # 53

That: if the proposed system is not implemented, consideration be given to scheduling a repeat Assessment project in five (5) years time.

Discussion

Health and Social Services require current statistical data on the characteristics and needs of clients to facilitate the planning and provision of services.

A client information listing should be developed to:

1. provide planners and providers with detailed statistical information which characterizes and identifies the needs of clients both in the N.W.T. and in southern care facilities;

2. provide for a review of the programs and services being used by clients as well as to indicate the unmet service requirements and duplicate services;

3. monitor changes in the status (level of care/need) of individuals and groups of individuals so that any trends are identified (data may form the basis for predictions on future needs);

4. review utilization patterns of programs/services.

If there is no ongoing methodology to update this information, this assessment project will have to be repeated in no more than five years in order to again have data from which to plan.

If this approach is taken, consideration should be given to funding for:

1. Three(3) project officers for 12 months;
2. travel to all communities;
3. access to computer services;
4. dedicated staff support for data preparation and entry, and for report preparation and typing.

5.3.C.3 REVISIONS TO CURRENT ASSESSMENT FORMS

Recommendation # 54

That: existing assessment forms and brochures be reviewed and revised with clarified terminology prior to next reprint.

Recommendation # 55

That: assessment forms be distributed with an explanation of proper completion for reference.

DISCUSSION

There are two forms which are currently used by the Departments of Health and Social Services to assess the health status and needs of the aged, disabled and chronically ill.

The Coordinated Homecare Assessment Record is completed by the Homecare Coordinators as an initial assessment of clients in the Homecare Program. Periodic re-assessments are done.

If it is suspected (or requested) that a client requires placement in a facility then the Assessment and Placement Record (green form) is completed. Any Health or Social Services professional familiar with the assessment process may complete the form. If the assessment indicates need for either Social Services or Health or other professional services, the client is directed to the appropriate agency or department.

Project officers found that the current A&P (green) forms were not well known to many community staff.

Some of the reasons for this may be:

- staff turnover;
- lack of forms manuals to keep track of all current forms in use, as well as a lack of completion instructions;
- mail problems, " I never received that ";
- never had to use it so it was in the "someday when I get to it" file.

For the system to work, the A&P records must be known and available to all workers in the field. Each of the regional offices and communities visited have now received a supply of forms. Project officers also discussed their (the forms) proper completion with the community nurses and social service workers.

By using the existing forms and by receiving comments from persons completing (or expected to complete) these in the communities, the need for form revision and clarity became evident.

5.3.C.4 INTER-AGENCY RELATIONSHIPS AND COMMUNICATIONS

Recommendation # 58

That: G.N.W.T.- Health, G.N.W.T.- Social Services, G.N.W.T.- Education, Health and Welfare Canada, and the N.W.T. Hospital's Association develop a joint, workable, clear and detailed policy on the mutual sharing and release of information that can be implemented by workers at the community level.

Discussion

On a number of occasions throughout the project, concerns were raised by community personnel about the need for development of better working arrangements for inter-agency discussion of client information.

Presently, each agency has a policy stating that information concerning their clients is CONFIDENTIAL and not to be released without the client's specific consent.

On the one hand, policies relating to disclosure of information are important to ensure the right to privacy and to maintain the element of trust between the client and service provider. On the other hand, there is the potential for unwitting damage to be caused because of this imposed "code of silence". The policy merits further review to ensure that what is being done is really in the client's best interest.

Example:

Resulting from concerns of teachers and the nursing station staff, a number of students were seen by an audiologist. A number of students were found to have varying degrees of hearing impairment. Despite the fact that the students had been referred by the school, the school was not informed of the results on the basis that this is medical/confidential and, therefore not releasable to them. As a result, those who are attempting to teach these children are not receiving assistance in what they could/would be doing to help the child e.g. seating the child with his/her good ear towards the teacher (instead of away) and encouraging the student in wearing his/her aid. As well, on several occasions, hearing aids have arrived at the school for certain children without prior notice.

When an explanation was requested, the project officer was told that it was because of the "disclosure of information" policy being strictly applied. From this example we see that good inter-agency communication of simple and certainly not highly confidential information would be in the best interest of the child.

5.3.C.5 TRANSLATION OF INFORMATION

Recommendation # 57

That: the next revision and printing of information concerning "Services to the Aged and Disabled" and other program brochures be translated and available in print or on audio cassette.

Discussion

In meetings with community leaders it was often necessary to speak through interpreters. They expressed the need for the translation of information so that it could be discussed and considered when they were considering programs/services for the people of their community.

5.3.C.6 LEVELS OF CARE

Recommendation # 58

That: the Departments of Health and Social Services review and redefine the existing levels of care and expand these to include consideration of community based care for Levels II and III.

Discussion

The current leveling system for Aged, Disabled, and Chronically ill clients needing care is institutionally oriented e.g. Level 2 - Personal care home, Level 3/Nursing home care. This system infers that a person assessed as Level 2 or 3 has to be placed in institutional care. The main focus of assessments should be on the client's needs and what can be done to support their care in their home community. The same care requirements can be met in a variety of ways depending upon the existing resources. For this reason, project officers recommend that a social/development model be considered. This model would not require a "levelling" structure but would use need as the criteria for entry, not level. Maintaining care levels as indicators for program services does not allow for assessment of the individual's unique situation. Work on standardizing the levels of care definitions has begun at the inter-provincial level and information from this working group should be considered when redefining levels of care in the N.W.T.

5.3.C.7 COMMUNITY VISITS

Recommendation # 59

That: priority be given to visiting communities for which no assessment information is available.

Discussion

A number of communities were not visited (See Section 7 Appendix 10).

In some cases, information that was obtained is included with a nearby community (e.g. Rae Edzo Group), in some cases information was obtained from professional sources in the communities. A few communities had themselves done earlier surveys (e.g. Fort Resolution) and these were used to provide the needed information. There remain a few communities for which no information was obtained and this could possibly be obtained by phone although a personal visit would be preferable.

Section 6

GLOSSARY

Section 6: GLOSSARY

Aged: A senior citizen who is 65+. Other terms which will be used interchangeably are: the "elderly", "older person" and "pensioner".

At risk: A fairly well person, but subject to failing health at any time: e.g. a frail 50 year old, recovered stroke who is less than 65 and a severe alcoholic.

Chronically ill person:
Any individual with a chronic disease which is, or is likely to be, permanently disabling and requiring, or likely to require, health and social services to intervene: e.g. the alcoholic diabetic, the arthritic, severe hypertension.

C.H.R.: Community Health Representative.

C.O.L.D./C.O.P.D.:
Chronic Obstructive Lung/Pulmonary Disease.

Continuum of care:

The system of linkage between home services, alternate accommodation, long-term care facilities and hospitals to ensure continuity of care. It involves the uninterrupted provision of the most appropriate care/service in the most appropriate setting whether it be providing care in the person's home, an alternate residence or an institution.

Disability:
A person's inability, because of some impairment, to perform the tasks and activities he or she wants to do at the level expected of someone of his or her age. An impairment such as arthritis might be a disability to someone who has to haul and cut firewood, for example, when they are trying to do that, but it might not be a problem for them at other times.

Disabled person:
Is an individual who possesses a physical, mental and/or emotional problem which requires, or is likely to require, Health and/or Social Services to intervene: e.g. blind, accident victim, spina bifida, severely retarded.

Future: In the opinion of the Assessor(s) these particular clients are "at risk" and will likely require some level of service in the reasonably forseeable future (1-15 years).

Handicap:
A person's inability, because of their impairment, to carry out their usual social role and function. Failing vision would be a severe handicap to a traditional Inuit woman whose role included sewing the family kamiks every year. Arthritis might be a severe handicap to an elderly couple who live in a tent or log house with wood heat. If neither were able to fetch and cut wood, they would be unable to perform their usual social role and thus would be considered handicapped. However, if the same couple lived in an oil heated house, their arthritis impairment would not handicap them to the same extent. Handicap is thus a very socially determined concept. The degree of handicap often depends on the circumstances.

Health: The optimum functioning of an individual physically, mentally and socially - and not merely the absence of illness or infirmity.

Impairment:
Alteration/disturbance of physical, mental or emotional health. Some examples are mental retardation, organic brain syndrome, blindness, hearing handicap and deformities.

Long-term Care:
All continuing care provided to aged, disabled or chronically ill persons whether or not it is institutional or community based care.

Senior citizen:
A person 65 years of age and over.

RN: Registered nurse.

CHN: Community Health nurse working in a nursing station.

Section 7

Appendicies

COMMUNITY ASSESSMENT PROFILE

COMMUNITY: _____

ASSESSMENT PROJECT 1985/86:

AGED, DISABLED & CHRONICALLY ILL PERSONS

1.0 FACILITIES

1.1 General Hospital

Name _____

# of beds _____

# of beds occupied by persons 65 plus (estimate) _____

# of outpatient visits per month (average) _____

1.2 Health Centre/Nsg. Station

of RN's _____

other staff _____

Holding Beds _____

Note: If no facility exists, what is nearest source of health care? _____

_____

1.3 Extended Chronic Care

Name _____

# of beds _____

Occupancy _____

Waiting list _____

1.4 Personal Care Home

Name _____

Capacity _____

Occupancy _____

on waiting list _____

1.5 Senior Citizen Unit

Name _____

Capacity _____

Occupancy _____

Length of waiting list _____

1.6 Foster Home

Name _____

Capacity _____

# of persons in facility at present

_____

1.7 Room and Board Homes

Name _____

Capacity _____

# of persons presently at this home _____

_____

Note: If combined with another type of facility please so indicate eg. 1.4 and 1.5.

2.0 ASSESSMENT OF NEED FOR HOME CARE

2.1 Description of Community

Describe the area to be covered by the program, either for a proposed program or expansion of a program now available. (e.g., town/village/settlement limits)

_____

_____

_____

_____

2.2 Population Composition

2.2.1 Total population of area _____ Date _____

Source of statistics _____

2.2.2 Population breakdown:

0 - 14 yrs. of age _____
15 - 29 yrs. of age _____
30 - 44 yrs. of age _____
45 - 59 yrs. of age _____
60 - 64 yrs. of age _____
65 - 74 yrs. of age _____
75 - 84 yrs. of age _____
85 plus yrs. of age _____

Source of statistics _____

_____

2.3 Estimate the number of potential recipients of Home Care Services in the following categories:

2.3.1 Elderly (65 plus) _____

2.3.2 Handicapped/chronic disabled (does not include elderly) _____

2.3.3 Acute hospital discharge _____/month

2.3.4 Mental hospital discharges (requiring follow up) _____/month

2.3.5 Children - handicapped _____/month

- hospital discharges _____/month

2.3.6 Maternity cases _____/month

2.3.7 Other _____

Source of information _____

3.0 HOME NURSING

3.1 Does a Home Nursing service presently exist in the community _____

3.2 If yes, who provides it _____

3.3 Who receives it (Briefly describe the target group, estimate the number receiving the service/month)

_____

_____

3.4 Source of information _____

3.5 Is there a cost to the receiver of this service YES ☐ NO ☐

If yes, specify _____

3.6 Might this program be expanded in the future YES ☐ NO ☐

If no service presently existing in the community, estimate the number of persons whom you feel may require this service _____/month

Source of information _____

3.7 To identify potential resources available for such a service: List the number of:

3.7.1 Public Health Nurses (currently employed) _____

3.7.2 Hospital Nurses _____

3.7.3 Inactive Nurses with current registration who might work part-time _____

_____

3.7.4 Inactive C.N.A.'s with current registration _____

3.7.5 Other, specify _____

_____

4.0 HOMEMAKERS

4.1 Does a homemaker service already exist YES ☐ NO ☐

If yes, indicate the number of homemakers _____

If yes, indicate the number of recipients of the service _____/month

Who provides the service _____

4.2 Cost of service to user _____

4.3 Funded by: ☐ G.N.W.T. - Social Services

☐ Other (Specify)_____

4.4 If no service existing:

Are there persons or service agencies to train homemakers?

YES ☐ NO ☐

If yes, who _____

Are there persons in the community who might work as homemakers?

YES ☐ NO ☐ UNKNOWN ☐

If yes, how many _____

Are these persons or groups in the community willing to start such a service?

YES ☐ NO ☐ UNKNOWN ☐

If so, specify _____

_____

_____

5.0 MEALS ON WHEELS

5.1 Is there a meals on wheels service at present? YES ☐ NO ☐

If yes, who provides this service _____

Cost of service to user _____

Funded by: ☐ G.N.W.T. - Social Services

☐ Other (Specify) _____

5.2 Who prepares the meals _____

Who delivers the meals _____

5.3 If this service is not available where might the meals for a meals on wheels program be prepared:

_____ hospital _____ home _____ restaurant _____ other, specify

_____

Who would deliver the meals _____

How often would meals be available _____

Estimate the number of persons requiring this service _____

Source of information _____

Additional Information:

_____

_____

_____

6.0 TRANSPORTATION

6.1 Is there a transportation service in the community?

YES ☐ NO ☐

If yes, who provides it?

- ☐ Government vehicle
- ☐ Taxi
- ☐ Other, specify _____

Is this service available for people in need, e.g., the aged, and disabled _____
What is cost to user _____

6.2 Is it suitable for persons such as the aged and disabled (e.g. Accessable for wheelchair)?

YES ☐ NO ☐

If there is no service at present are there individuals or groups interested in developing this service?

YES ☐ NO ☐ UNKNOWN ☐

If so, specify _____

Additional information:

_____

_____

_____

7.0 HANDYMAN SERVICE

7.1 Is this service available in the community? YES ☐ NO ☐

If yes, who provides it _____

Funded by:

- ☐ G.N.W.T. - Social Services
- ☐ Other (Specify)_____

How many persons use this service _____

Contact Person: (Name) _____

(Address) _____

_____

7.2 Cost to user _____

If no service is available at present, estimate the number of persons in the community who might use this service _____

Source of information _____

Are there individuals or groups interested in forming such a service _____

If so, specify _____

8.0 PROFESSIONAL SERVICES

8.1 What professional services are available to this community: (currently active in their profession) (enter number available)

_____ Nutritionist/Dietician	_____ Occupational Therapist
_____ Speech therapist	_____ Physiotherapist
_____ Public Health Nurse	_____ Social Worker
_____ Registered Nurse	_____ Physician
_____ Mental Health Worker	_____ Psychologist

8.2 What professional services are available to the community on a consultant basis?

_____

_____

Are there any qualified professionals (currently unemployed) in the community who might consider employment on a full or part time basis _____

9.0 MEDICAL EQUIPMENT LOAN

Is there a service or agency in the community from which equipment such as crutches, wheelchair, canes, etc. may be loaned?

YES ☐ NO ☐

If so, who provides it _____

Location _____

Any charge (user fee) _____

9.2 If no equipment service is available:

Estimate how many persons might use this service _____

Source of information _____

9.3 What kinds of equipment might be needed:

_____ wheelchair	_____ cane	_____ sheepskin
_____ walker	_____ bedpans, urinal	_____ kitchen aid
_____ crutches	_____ commode chair	_____ other

10.0 FRIENDLY VISITING — VOLUNTEER SERVICES

10.1 Is there an established friendly visiting service in the community?

YES ☐ NO ☐

10.2 If yes, who provides it _____

10.3 If no, are there individuals or groups interested in providing such a service _____

10.4 Estimate the number of persons who might benefit from such a service _____

Source of information _____

11.0 ACCESS TO COMMUNITY BUILDING

	Municipal/Settlement Office	Nursing Station/ H.C. Facility	Community/Rec. Hall	School(s)	Churches(s)	Store(s)	Post Office	Other
STAIRS ONLY	☐	☐	☐	☐	☐	☐	☐	☐
RAMP(S)	☐	☐	☐	☐	☐	☐	☐	☐
BOTH STAIRS AND RAMP	☐	☐	☐	☐	☐	☐	☐	☐
HAND RAIL(S)	☐	☐	☐	☐	☐	☐	☐	☐
DOORS (THAT PERMIT W.C. ACCESS)	☐	☐	☐	☐	☐	☐	☐	☐
WASHROOM(S) (THAT PERMIT W.C. ACCESS)	☐	☐	☐	☐	☐	☐	☐	☐

COMMENTS:

Date:_____/85 Profile Completed by: _____

Date:_____/85 Reviewed by: _____
Project Assessment Officer

AGED DISABLED & CHRONICALLY ILL ASSESSMENT PROJECT 85/86
G.N.W.T. Departments of Health & Social Services

PAGE ___ OF ___

CLIENT LISTING

COMMUNITY _____

Name	D.O.B.	SEX	H.C.P.#	CONDITION/ DISABILITY	PLACEMENT SITUATION	LEVEL OF CARE	MISCELLANEOUS COMMENTS

APPENDIX 7.5

The provision of services to the aged and disabled is shared between the Department of Health and the Department of Social Services. The mechanism to determine departmental responsibilities is based on levels of care which are determined through an assessment process. There are 6 levels designated as follows:

Level 1 - Supervisory Care

The level of care required by a client who is essentially independent and shows only a slight impairment (physical frailty and/or minor mental deterioration).

The care required is mainly guidance or supervision with activities of daily living, i.e. laundry services, shopping and reminders to take medications.

Supervisory care may be provided in the client's own home, self-contained senior citizens unit, extended family home, boarding or foster home.

Responsibility:

Not an insured service.

Client is expected to pay, but if unable to pay the full amount, the Department of Social Services will share the cost.

Level 2 - Personal Care

The level of care required by a client who shows impairment of physical and/or mental faculties to a degree which requires supervision and assistance with activities of daily living, i.e. hygiene and grooming, meals, laundry, and housekeeping services.

The client is able to get around safely with or without aides, is able to feed him/herself and is usually continent.

Personal Care is 24 hour custodial care and may be provided in an extended family or foster home with support services, adult residential care facility, or personal care home.

Responsibility:

Not an insured service.

Client is expected to pay, but if unable to pay the full amount the Department of Social Services will share the cost.

Level 3 - Nursing Home

A level of care required by clients who have advanced physical and/or mental illness that is reasonably stabilized and which is not expected to deteriorate in the near future (barring an accident or additional disease).

The Client:

- shows changes due to aging combined with chronic disease, or is of any age with an advanced stage of a chronic illness
- and/or suffers from mental deterioration due to senility, mental retardation or psychiatric disorder making them harmful to themselves or others or to property, they may have a tendency to wander occasionally
- can walk or walk with aid, confined to wheelchair, or bedrest
- requires personal care such as hygene and grooming
- may require nursing care including administration of drugs

This care is normally carried out in a Nursing Home or similar facility with adequate staff and equipment. The client's health care practitioner is responsible for prescribing appropriate medical care. Daily care is supervised by a registered nurse (on site for at least 8 hours a day and available on call during remaining hours) but is rendered primarily by nursing aides. These clients benefit from simple rehabilitation designed to reactivitate or to maintain the highest possible level of function physically and socially.

Responsibility:

This level of care is the responsibility of the NWT Health Care Plan when provided in a Nursing Home or approved facility. A co-payment system is utilized in that the client contributes towards his/her care based on income level and the ability to pay. The co-payment goes towards costs related to room and board. Medical and Nursing Services are fully insured.

Level 4 - Extended/Chronic Care

The level of care required by clients of all ages who require regular and continuous medical attention, highly skilled technical nursing supervision on a 24 hour basis, and special techniques for improvement and maintenance of function. Appropriate diagnostic treatment facilities must be readily available.

The Client:

- may suffer from advanced chronic illness or disabilities, and/or advanced mental deterioration characterized by wandering tendencies or aggressive behaviour
- may be fully mobile or confined to bed
- may be capable of self-feeding or may need to be fed
- is moderately to completely dependent in activities of daily living
- requires nursing care
- requires social, recreational, physical and/or occupational therapy

Treatment is required by these clients to:

- control the disease
- achieve maximum recovery of function
- prevent further disability
- retard deterioration
- alleviate pain and distress

Such care is provided in an extended/chronic care unit in a hospital setting.

Responsibility:
This level of care is the responsibility of the NWT Health Care Plan when provided in a hospital or approved facility. A co-payment system is utilized in that the client contributes towards his/her care based on income level and the ability to pay. The co-payment goes towards costs related to room and board. Medical and Nursing Services are fully insured.

Level 5 - Intensive Rehabilitation Care

Rehabilitation care is intended for persons with physical disabilities who require intensive therapy by a rehabilitation team. Maximum benefit of restoring or improving function should be anticipated to be obtained within three months. At such time as this occurs, the patient is transferred home or to another facility for a more appropriate level of care.

The Client:

- is suffering from physical disabilities resulting from injuries or illness or congenital conditions
- may have a disease requiring investigation and treatment
- could have emotional problems as a result of physical disability and may require psychiatric treatment as well as physical restoration
- may be independently mobile or may be completely dependent

Responsibility:
Insured service of the NWT Health Care Plan when provided at territorial and provincially recognized facilities.

Level 6 - Acute Care

This level of care is short term for persons of all ages requiring 24 hour medical/nursing supervision for diagnosis and treatment in specialized hospitals. Also included are out-patient services and day hospitals for mental illness.

Such care is received as an inpatient in a NWT hospital or as an inpatient in an acute care hospital in Southern Canada. In addition, care may be given on a day basis, with admission in the morning and discharge in late afternoon.

The client may have one or more of the following:

- an acute illness or disability requiring medical treatment and nursing care
- a requirement for surgery to restore health or to prevent illness
- an acute episode of mental illness
- confinement for childbirth

Responsibility:
Insured service of the NWT Health Care Plan when provided at territorial and provincially recognized facilities.

Additional information may be obtained by referring to the publication "Services to the Aged and Disabled" (August 1984) or contacting
The Department of Health
Phone 403-873-7711
or
The Department of Social Services
Phone 403-873-7707
Government of the Northwest Territories
Yellowknife, N.W.T. X1A 2L9

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N.W.T. POPULATION PROJECTIONS BY AGE, BY ETHNICITY, 1986 to 2001.

Year	Group	Sex	All Ages	0-14	15-64	65+
1986	All Groups	T	52,064	17,849	32,752	1463
		M	27,319	9,266	17,247	806
		F	24,745	8,583	15,505	657
	Dene/Metis	T	11,841	4,228	7,011	602
		M	6,129	2,197	3,618	314
		F	5,712	2,031	3,393	288
	Inuit	T	18,650	7,845	10,309	496
		M	9,555	4,076	5,206	273
		F	9,095	3,769	5,103	233
	Non native	T	21,573	5,776	15,432	365
		M	11,635	2,993	8,423	219
		F	9,936	2,783	7,009	146
1991	All Groups	T	56,987	19,366	35,681	1,940
		M	29,672	10,097	18,676	1,099
		F	27,115	9,269	17,005	841
	Dene/Metis	T	13,064	4,393	7,942	729
		M	6,770	2,289	4,089	392
		F	6,294	2,104	3,853	337
	Inuit	T	21,656	9,015	12,024	617
		M	11,112	4,715	6,051	346
		F	10,544	4,300	5,973	271
	Non Native	T	22,267	5,958	15,715	594
		M	11,990	3,093	8,536	361
		F	10,277	2,865	7,179	233
1996	All Groups	T	62,061	20,858	38,704	2,499
		M	32,493	10,892	20,160	1,441
		F	29,568	9,966	18,544	1,058
	Dene/Metis	T	14,358	4,667	8,835	856
		M	7,445	2,454	4,530	461
		F	6,913	2,213	4,305	395
	Inuit	T	24,793	10,164	13,848	781
		M	12,743	5,291	7,020	432
		F	12,050	4,873	6,828	349
	Non Native	T	22,910	6,027	16,021	862
		M	12,305	3,147	8,610	548
		F	10,605	2,880	7,411	314

2001	All Groups	T	67,019	21,803	42,087	3,129
		M	35,034	11,376	21,899	1,759
		F	31,985	10,427	20,188	1,370
	Dene/Metis	T	15,641	4,907	9,780	954
		M	8,106	2,565	5,024	517
		F	7,535	2,342	4,756	437
	Inuit	T	27,938	10,903	15,993	1,042
		M	14,372	5,668	8,152	552
		F	13,566	5,235	7,841	490
	Non Native	T	23,440	5,993	16,314	1,133
		M	12,556	3,143	8,723	690
		F	10,884	2,850	7,591	443

Source: Preliminary Projections,
Bureau of Statistics,
Government of the N.W.T.
May, 1986

N&T FACILITIES PROVIDING SENIORS HOUSING AND LEVEL I TO IV CARE BY REGION, COMMUNITY, BY LEVELS OF CARE AS AT NOVEMBER, 1986

NAME	ADDRESS	SENIOR CITIZENS HOUSING UNITS	NUMBER OF BEDS		LEVEL I - IV TOTAL NUMBER OF BEDS	ACUTE CARE BEDS	OWNERSHIP
			LEVELS I AND II	LEVEL III/IV CHRONIC CARE			
A. BAFFIN REGION							
1. Baffin Regional Hospital	Bag 200 Frobisher Bay, N&T X0A 0H0 (819) 979-5231					34	Government of the Northwest Territories
B. FORT SMITH REGION							
1. Senior's Home	Ft. Liard, N&T	3					Community/Band Council
2. Deh Gah Gotie Koe	Fort Providence Housing General Delivery Ft. Providence, N&T X0E 0L0 (403) 699-4451	25	4		4		Federal/Territorial Government
3. Jimmy Erasmus Senior Citizens Home	Rae-Edzo Housing Association P.O. Box 66 Yellowknife, N&T X0E 0Y0	14	8		8		Federal/Territorial Government
4. Fort Resolution Senior Citizens Home	Denínoo Housing Authority General Delivery Ft. Resolution, N&T X0E 0P0	8					Federal/Territorial Government
5. Fort Simpson Senior Citizens Home	Ft. Simpson Housing Authority P.O. Box 378 Ft. Simpson, N&T X0E 0N0	8					Federal/Territorial Government

NAME	ADDRESS	SENIOR CITIZENS HOUSING UNITS	NUMBER OF BEDS		LEVEL I - IV TOTAL NUMBER OF BEDS	ACUTE CARE BEDS	OWNERSHIP
			LEVELS I AND II	LEVEL III/IV CHRONIC CARE			
8. FORT SMITH REGION Continued							
6. Ft. Simpson Hospital	Box 246 Ft. Simpson, NWT X0E 0N0			2	2	12	Federal/Territorial Government
7. Sunset Chalet	Ft. Smith Housing Authority P.O. Box 1287 Fort Smith, NWT X0E 0P0	29					Federal/Territorial Government
8. Ft. Smith Personal Care Unit (pink house)	Ft. Smith, NWT X0E 0N0		6		6		Government of the Northwest Territories
9. Ft. Smith Health Centre	Ft. Smith, NWT X0E 0N0 (403) 872-2713 Admin.: Joyce Balla			10	10	15	Government of the Northwest Territories
10. Riverview Lodge	Hay River Housing Authority P.O. Box 1517 Hay River, NWT X0E 0R0	16					Federal/Territorial Government
11. H.H. Williams Memorial Hospital	P.O. Box 280 Hay River, NWT X0E 0R0 (403) 874-6512 Admin.: Jim Tyler			16	16	34	Government of the Northwest Territories

NAME	ADDRESS	SENIOR CITIZENS HOUSING UNITS	NUMBER OF BEDS		LEVEL I - IV TOTAL NUMBER OF BEDS	ACUTE CARE BEDS	OWNERSHIP
			LEVELS I AND II	LEVEL III/IV CHRONIC CARE			
B. FORT SMITH REGION Continued							
12. Mary Murphy Senior Citizen Home	Yellowknife Housing Authority P.O. Box 2197 Yellowknife, NWT X1A 2P8	17					Federal/Territorial Government
13. Forest Drive Senior Residence	Yellowknife, NWT X1A 2N8		8		8		Government of the Northwest Territories
14. Stanton Yellowknife Hospital	P.O. Box 10 Yellowknife, NWT X1A 2N1 (403) 920-4111 Admin.: Larry Todd			(4) acute beds are used	4	72	Government of the Northwest Territories
15. Yellowknife Personal Care Home	Y.A.C.C.S. Yellowknife, NWT Admin.: C. Praamsma		(30)				currently under construction opening Feb./87.
C. KEEWATIN REGION							
1. Joe Greenland Centre	Aklavik Housing Association General Delivery Aklavik, NWT X0E 0A0 (403) 978-2381	7	8				Federal/Territorial Government

NAME	ADDRESS	SENIOR CITIZENS HOUSING UNITS	NUMBER OF BEDS		LEVEL I - IV TOTAL NUMBER OF BEDS	ACUTE CARE BEDS	OWNERSHIP
			LEVELS I AND II	LEVEL III/IV CHRONIC CARE			
C. INUVIK REGION continued							
2. Fort Good Hope Senior Citizen Home	Ft. Good Hope Housing Assoc. General Delivery Ft. Good Hope, NWT X0E 0H0	8					Federal/Territorial Government
3. Fort McPherson Senior Citizen Home	Fort McPherson Housing Assoc. P.O. Box 4 Ft. McPherson, NWT X0E 0J0	8					Federal/Territorial Government
4. Inuvik Senior Citizen Home	Inuvik Housing Association Inuvik, NWT X0E 0T0	10					Federal/Territorial Government
5. Inuvik Long Term Care Facility	Inuvik General Hospital Inuvik, NWT X0E 0T0 (403) 979-2955 Admin.: Ed Norwich			16	16		Government of the Northwest Territories
6. Inuvik General Hospital	Inuvik General Hospital Inuvik, NWT X0E 0T0 (403) 979-2955 Admin.: Ed Norwich					45	Federal Government

NAME	ADDRESS	SENIOR CITIZENS HOUSING UNITS	NUMBER OF BEDS		LEVEL I - IV TOTAL NUMBER OF BEDS	ACUTE CARE BEDS	OWNERSHIP
			LEVELS I AND II	LEVEL III/IV CHRONIC CARE			
C. INUVIK REGION continued							
7. Inuit Non-Profit Housing Corp. Senior Citizen Home	Tuktoyaktuk Housing Assoc. P.O. Box 150 Tuktoyaktuk, NWT X0E 1C0	6					Inuit Non-Profit Housing Corporation, 176 Gloucester Street, 3rd Floor, Ottawa, Ontario K2P 0A6
D. KEEWATIN REGION							
1. Ste. Therese's Home	Chesterfield Inlet, NWT X0C 1C0 (819) 898-9917 Admin: Sr. Isabelle		4	8	12		Religious, Order of Grey Nuns
E. KITIKMEOT REGION NIL							
	TOTAL	159	38	52	90	212	

*NOTE

The 30 bed Yellowknife Personal Care Home is not included in the Total of Personal Care Beds as it is not yet in operation.

ORGANIZATIONAL OVERVIEW OF SERVICE DELIVERY ADMINISTRATIVE FRAMEWORK FOR DELIVERY OF CONTINUING CARE

LEVEL	RESPONSIBILITY	SUPPORTS
Local Community	Nurse-in-charge	(A) Local Health Committee (B) Support staff (*) of: - nurse(s) - homemaker(s) - clerk/interpreter(s) - Community Health Reps. - mental health worker(s) - dental therapist(s) - rehabilitation staff (speech, audiology, O.T., P.T. * The size and complexity of local community staff will vary with needs - not every component will necessarily be available in each community.
Regional	Co-ordinator of Continuing Care	(A) Regional Continuing Care Advisory Council (b) Finance and administration support
Territorial	Director of Continuing Care	(A) Territorial Continuing Care committee (B) Staffing to provide: Financial management Administration support Consulting Services in: - Gerontology - Nursing Care - Social Services - Mental Health - activity and day programs - rehabilitation - staff training and development

APPENDIX 7.9